

The Medical Malpractice “Crisis”: Myth and Reality

BY BURTON CRAIG

The insurance industry tells us that we are in the midst of a grave “medical malpractice crisis.” Every day, we hear claims in the media that doctors are “abandoning their profession” because of “skyrocketing insurance premiums,” and that “runaway juries” are routinely subjecting innocent doctors and hospitals to “outrageous verdicts.” The villain in these stories is invariably the avaricious lawyer who makes his living filing “frivolous lawsuits.”

What makes these stories so remarkable is that they are utterly contrary to the facts in North Carolina. The campaign for “malpractice reform” is fueled by four myths, none of which have any basis in reality.

Myth No. 1: “An explosion of frivolous lawsuits.”

Four years ago, the National Academy of Sciences’ Institute of Medicine concluded that between 44,000 and 98,000 Americans die every year in hospitals because of preventable medical errors.¹ Based on those statistics, 1,200 to 2,800 North Carolinians die in hos-

pitals each year as a result of medical mistakes—an average of three to eight deaths per day.² The number of non-fatal injuries caused by medical errors far exceeds the number of deaths. A recent study by the Commonwealth Fund showed that injuries caused by preventable errors occur in about two percent of hospitalizations.³ At that rate, approximately 18,000 North Carolinians are injured by medical mistakes in hospitals each year.⁴ That figure understates the human toll of malpractice, because it does not include those who are injured by medical negligence outside hospitals.⁵



In view of this epidemic of injuries caused by medical negligence, the number of malpractice lawsuits filed in North Carolina is remarkably small. Injured patients filed an average of 617 medical malpractice suits per year from 1998 through 2003—only a fraction of the thousands injured or killed by malpractice. The number of malpractice filings has been stable, rising only 1.0% per year from 2000 to 2003⁶—less than the rate of population growth in North Carolina,⁷ and far less than the rate of growth of the state’s physician population.⁸

Formidable legal and economic barriers

combine to discourage patients from filing malpractice claims. Rule 9(j) of the North Carolina Rules of Civil Procedure—a procedural hurdle that applies only to malpractice cases—provides that an injured patient cannot file a malpractice lawsuit unless a qualified doctor has determined that the claim has merit and is willing to testify. Patients face the daunting task of finding medical experts who will break the “code of silence” and testify against a colleague. Malpractice cases are notoriously expensive and difficult to win. The routine malpractice case requires the patient and her lawyer to incur upwards of \$50,000 in litigation expenses. The complex case requires an investment of more than \$100,000 in expenses, and many hundreds of hours of attorney time. If the patient loses, neither the patient nor the lawyer is paid anything. Recognizing these obstacles, attorneys know they risk financial ruin unless they file well-founded malpractice claims.

Myth No. 2: “Outrageous jury verdicts.”

North Carolina juries are conservative in medical malpractice cases, consistently favoring the health care provider over the patient. Studies have repeatedly confirmed what lawyers know from experience: malpractice plaintiffs in North Carolina win at trial about 20% of the time.⁹ In the rare case that a plaintiff obtains a favorable verdict, the amount of the award reflects the severity of the injuries and the cost of treatment. If the jury’s award is excessive and unsupported by the evidence, the trial judge will throw out the verdict and order a new trial.

In 1998 the North Carolina Administrative Office of the Courts (AOC) began to compile data on medical malpractice lawsuits. The AOC data demolish the contention that malpractice defendants need legislative protection from North Carolina juries. Patients and their families filed 3,700 medical malpractice lawsuits between 1998 and 2003.¹⁰ Of those cases, 2,772 had been resolved as of the beginning of 2004.¹¹ Among the resolved medical malpractice lawsuits, 99 (4%) went to trial.¹² Of the 99 tried cases, only 21 (21.2%) were decided in favor of the plaintiff.¹³ The median jury award was \$300,000, with only three verdicts of more than \$1 million.¹⁴

Myth No. 3: “Malpractice insurance premiums are skyrocketing.”

From 1989 through 2002, Medical

Mutual of North Carolina—the largest writer of malpractice insurance in North Carolina—increased its base premium rate 3.8% per year.¹⁵ During the same period, the cost of medical services, including physicians’ services, increased at an average annual rate of 5.3%.¹⁶ Thus, victims of malpractice faced sharper increases in medical costs for treating their injuries than doctors faced in their liability premiums.

In 2001 and 2002, when the stock and bond markets dropped sharply, insurers raised premiums to compensate for a lower return on their investments.¹⁷ In 2002, Medical Mutual increased its premiums by 12%.¹⁸ That increase was modest in comparison with premium hikes consumers faced for property, casualty, and health insurance.¹⁹

Even with recent increases, most North Carolina physicians pay moderate malpractice premiums. In its 2003 rate filing to the North Carolina Department of Insurance, Medical Mutual disclosed that the average collected rate per insured in 2002 was \$9,192.²⁰ Those rates are comparable to premiums charged by other companies. The North Carolina Department of Insurance recently released comprehensive data demonstrating that the average earned premium per physician in 2002 was less than \$9,000.²¹

Myth No. 4: “Doctors are leaving North Carolina because of malpractice lawsuits and high insurance premiums.”

The number of physicians per person in North Carolina has risen steadily, from 12 doctors per 10,000 population in 1979 to 16 per 10,000 in 1990 to 20 per 10,000 in 2001.²²

We hear claims that obstetricians are leaving North Carolina in droves because of malpractice lawsuits. Let’s look at the facts. From 1995 to 2000, the population of North Carolina increased from 7.2 million to 8.2 million—an increase of 2.3% per year.²³ During the same period, the number of obstetricians practicing in North Carolina increased from 747 to 937—an annual rate of increase of 4.2%.²⁴ In other words, the number of obstetricians in North Carolina has grown almost twice as fast as the state’s population.

Recent studies by the General Accounting Office refute the notion that malpractice lawsuits are causing a crisis in access to health care. The GAO carefully reviewed reports by provider groups in five states claiming that

malpractice pressures had caused physicians to close their practices or reduce services. The GAO found that problems were “limited to scattered, often rural, locations and in most cases providers identified long-standing factors in addition to malpractice pressures that affected the availability of services.”²⁵ Those “long-standing factors,” familiar to most health care providers in rural North Carolina, include professional isolation and distance from major medical centers.

Although the traditional gap in access between rural and urban areas persists, striking new evidence shows that North Carolina is narrowing the gap. A GAO report released in October 2003 confirms rapid physician growth in metropolitan North Carolina, with the number of physicians per 100,000 population increasing from 221 in 1991 to 257 in 2001, an increase of 16.3%.²⁶ At the same time, the number of physicians per 100,000 population in nonmetropolitan North Carolina grew almost twice as fast, from 96 to 125, a 30.2% increase.²⁷ Thus the facts belie the claim that the General Assembly needs to enact radical malpractice “reform” to stem an exodus of doctors from rural North Carolina.

The lobbyists for the insurance industry say that North Carolina will attract more doctors if we copy the malpractice “reforms” that California enacted in 1975.²⁸ But while North Carolina’s doctor population was rapidly growing in the 1990’s, the number of doctors per capita in California was stagnant. In nonmetropolitan areas from 1991 to 2001, the number of physicians per capita grew twice as fast in North Carolina as in California (30.2% v. 15.2%).²⁹ From 1991 to 2001, while the number of physicians per capita in metropolitan areas increased 16.3% in North Carolina, the rate of growth in California was only 1.8%.³⁰ Doctors are flocking to North Carolina and abandoning California. Why should we follow California’s example?

“Defensive Medicine”

Advocates for malpractice “reform” claim that the tort system increases medical costs by encouraging doctors to practice “defensive medicine” to avoid lawsuits. The argument fails to withstand scrutiny. A recent GAO report identifies numerous flaws in surveys purporting to demonstrate the prevalence and costs of “defensive medicine.”³¹ As the GAO notes, when health care providers have “revenue-enhancing motives” to order tests or

procedures, we should “interpret with caution” claims that those practices were induced by “defensive medicine.”³² Moreover, managed care has significantly mitigated the effect of defensive practices: in today’s environment, insurance companies will only pay for procedures of proven efficacy.³³

If a procedure is demonstrably effective and increases patient safety, a conscientious physician should offer that option to her patient, just as she would to a member of her own family. That is simply good medical care, not “defensive medicine.”

What Can Be Done?

Four constructive measures will protect patient safety and reduce premiums paid by health care providers:

1. **Reduce malpractice by reforming and strengthening the Medical Board.** The North Carolina Medical Board has been passive and ineffective in identifying and sanctioning incompetent physicians. When bad doctors are not disciplined, good doctors pay for their mistakes through higher premiums. The board should be reconstituted so that it is independent of the Medical Society, the doctors’ trade association. The new board should be adequately funded and staffed. When three or more malpractice payments have been made on behalf of a particular doctor, the board should be required to conduct an investigation of the physician and publicize its findings.

2. **Implement effective insurance regulation.** The commissioner of insurance should be given more power to regulate malpractice rates. Public hearings should be mandatory when a proposed rate hike exceeds 10%.

3. **Reduce litigation costs.** A significant factor driving premium increases is the rapid escalation in litigation expenses. Plaintiffs and defendants should be limited to two experts per side in a particular specialty. Expensive expert depositions should be replaced by written expert reports.

4. **Give targeted tax credits to physicians in underserved areas.** Doctors in critical specialties practicing in poor, underserved communities should receive tax credits for their premium payments.

Conclusion

For more than 200 years jurors in North Carolina have responsibly exercised their duty to determine fair compensation for people injured by negligence. We trust juries

to decide damages when someone is injured or killed in an automobile accident. We trust juries to make life or death decisions in death penalty cases. But now we are being told that juries and judges cannot be trusted to decide damages in medical malpractice cases, and that health care providers—unlike everyone else—should not be held fully accountable for the consequences of their negligence.

The legal system promotes patient safety by holding doctors, hospitals, and nursing homes accountable for their mistakes. Dismantling the mechanism that protects patient safety will only increase the risk of injury by medical errors. Consumer groups and health care providers should work together to prevent malpractice and implement effective insurance reform. Members of the legal profession should support measures to reduce litigation costs, while vigorously opposing attacks on the jury system. ■

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Endnotes

1. Kohn LT, Corrigan JM, Donaldson MS, eds., *To Err is Human: Building a Safer Health System*, National Academy Press, Institute of Medicine (2000).
2. Public Citizen’s Congress Watch, *Medical Misdiagnosis* (January 2003).
3. The Commonwealth Fund, *Quality of Healthcare in the United States: A Chartbook* (2002).
4. According to the “2000 County Health Databook,” published by the NC Department of Health and Human Services State Center for Health Statistics, there were 896,809 hospitalizations in North Carolina in 2000. An error rate of two percent yields 17,936 medical errors resulting in injuries.
5. A recent study documents a high incidence of medical errors in outpatient visits. Elder, Meulen and Cassidy, *The Identification of Medical Errors by Family Physicians During Outpatient Visits*, *Annals of Family Medicine* 2:125-29 (2004).
6. NC Administrative Office of the Courts, data on medical malpractice filings, 1998-2003 (January 2004). See North Carolina Academy of Trial Lawyers, *Medical Malpractice Lawsuits in North Carolina, 1998-2003* (April 14, 2004).
7. US Census Bureau, *State Population Estimates*.
8. NC Health Professional Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
9. Vidmar, N., *Medical Malpractice and the American Jury*, University of Michigan Press (1995); Peeples, Harris & Metzloff, *The Process of Managing Medical Malpractice Cases*, 37 *Wake Forest Law Review* 877, 887-88, 899 (2002) (Table 6) (plaintiff won 16.7% of cases tried).
10. North Carolina Administrative Office of the

Courts, data on medical malpractice filings, 1998-2003 (January 2004).

11. *Id.*
12. *Id.*
13. For every case that went to trial, the North Carolina Academy of Trial Lawyers (NCATL), with the assistance of the staff of county clerk of court offices, determined the disposition of the case and the amount of the verdict, if any. NCATL, *Medical Malpractice Lawsuits in North Carolina, 1998-2003* (April 14, 2004).
14. *Id.*
15. Annualization of data in Exhibit 6 of Medical Mutual Insurance Company of North Carolina rate filing with the NC Department of Insurance dated August 18, 2002, designated Rate/Rule Filing No. NC-R-020004.
16. United States Bureau of Labor Statistics, *Consumer Price Index - All Urban Consumers, Medical Care Services, 1989-2002*.
17. Oster and Zimmerman, *Insurer’s Price Wars Contributed to Doctors Facing Soaring Costs*, *Wall Street Journal*, June 24, 2002.
18. Exhibit 6 of Medical Mutual’s rate filing with the NC Department of Insurance dated August 18, 2002.
19. Treaster, *Insurance Rates Are Rising Sharply Across U.S.*, *New York Times*, October 24, 2002, and Crenshaw, *A Move to Halt the Premium Seesaw*, *Washington Post*, June 24, 2002.
20. Tillinghast-Towers Perrin actuarial memorandum included as exhibit in Medical Mutual Insurance Company of North Carolina rate filing with the NC Department of Insurance dated August 30, 2002, No.-R-030001.
21. N.C. Department of Insurance, presentation by Daschiel Propes to House Blue Ribbon Task Force on Medical Malpractice (December 3, 2003).
22. US Census Bureau, *State Population Estimates - North Carolina, 1979, 2001*; NC Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
23. US Census Bureau, *State Population Estimates*.
24. NC Health Professional Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
25. General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care* at 13 (August 2003).
26. General Accounting Office, *Physician Workforce*, Appendix III (October 2003).
27. *Id.*
28. The California “reforms” included a \$250,000 cap on noneconomic damages, caps on fees for plaintiff attorneys, abolition of the collateral source rule, and periodic payments of future medical expenses.
29. General Accounting Office, *Physician Workforce*, Appendix III (October 2003).
30. *Id.*
31. General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care* at 26-30 (August 2003).
32. *Id.* at 26, 27.
33. *Id.* at 27.