



CARDIOLOGY

On the Front Line of the Fight for Liability Reform

In March 2002, the headline on *Cardiology's* cover proclaimed that a medical liability crisis was gripping the nation and had "physicians searching for solutions." Twenty months later, the hunt is still on.

Medical liability insurance premiums in many states have continued a steady climb. And although high-risk specialties like neurosurgery and obstetrics/gynecology have experienced the most severe increases, relatively low-risk specialists like cardiologists also have been hit with liability premium sticker shock.

Suburban Cardiologists, S.C., a six-physician practice in Hinsdale, Ill., saw its liability premiums triple in 2003. The increase came after its insurer, PIC of Wisconsin, announced that it was exiting the medical liability market in northern Illinois. The practice found another liability insurer, but even with substantially decreased coverage, premiums are far more expensive than they were just a few years ago. Suburban's liability record over its 24-year history, volunteers its president, Alan L. Miller, MD, has been "impeccable," but there seems to be no respite from towering liability premiums.

"I'm trying to look at the future of my practice, and speaking from a business perspective, it's getting very serious," Dr. Miller says. With reimbursements cut by both private payers and Medicare, and with dramatically increased overhead and liability rates, the practice has done all the requisite belt-tightening it can.

"Physicians are just sort of absorbing all this—we're taking all the body blows now," Dr. Miller says. "We're protecting the patients from a very serious situation, but it's just a matter of time before they really start to feel it."

Illinois is one of 19 states particularly hard hit by the liability crisis. In western Washington (state), Terence Block, MD, a practicing cardiologist for 25 years and now chief medical officer of Valley Medical Center in Renton, has seen firsthand the tumult caused by a liability system that has spiraled out of control.



First, emergency room physicians at Valley Medical nearly lost their liability insurance, but got a renewal—at a considerable premium increase—at the last minute. Then, one of the hospital's on-call neurosurgeons lost his liability coverage for more than two weeks. His 10-man neurosurgeon group eventually found a new insurer, but with a 30 percent premium increase.

"We've been trying to get the state legislature to pass liability reform, but it's been unsuccessful thus far," Dr. Block says. And one of the most proven and effective reforms, caps on noneconomic damages would require an amendment to the state constitution.

"I don't think that's going to happen," he adds. "So, really, our only hope is [in] D.C."

Dr. Block is not alone in his belief. As an increasing number of states struggle with broken liability systems, more and more physicians are looking to Congress to step in. The ACC has long

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The medical liability system is broken in at least a dozen states and has suffered injury in still others. Physicians aren't going to stand for it any more.

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The College is relying on strong member support. “The liability crisis is serious and only getting worse. It is imperative that we join our physician colleagues to fight this nationwide problem.”

—ACC President
Carl J. Pepine, MD

California’s medical liability insurance premiums rose 167 percent on average from 1975 to 2003. Elsewhere in the United States, premiums increased 505 percent.

For 2000 and 2001, the median jury award in medical liability cases was \$1 million, according to the most recent data available from Jury Verdict Research.

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advocated for a federal solution to this liability morass. And although some progress has been made in Congress—namely, passage last summer by the House of a medical liability reform bill strongly favored by the ACC and other physician groups—getting a federal law through the narrowly divided Senate will be an arduous task.

Refuting Opponents

The physician community has strongly supported reforms that mirror those enacted in California in 1975—known as MICRA—that, among other things, cap noneconomic damages at \$250,000, tighten the statute of limitations on when cases can be brought, and ensure that damages received from other sources are accounted for in suits against providers. Because of such reforms, California’s medical liability insurance market has remained relatively stable over time.

The most contentious point in the liability reform debate has been the noneconomic damages cap. Physicians have argued that skyrocketing jury awards have fueled the rate hikes. The numbers seem to back that up: average jury awards increased by 76 percent between 1996 and 1999, and in 1999 and 2000, more than half of medical liability awards topped \$1 million.

Opponents of liability reform, particularly trial attorneys, have argued that premiums in California have remained stable not because of damage caps, but because of insurance industry reforms enacted well after MICRA. This argument has generally proven to be false, with MICRA proponents showing that liability premiums were already stabilized by the time the insurance reforms went into effect.

Opponents also claim that insurers are gouging physicians to make up for stock market investment losses. That argument is fraught with shortfalls. First, insurers’ investment practices are regulated in most states, so there are some checks in place to ensure insurers’ investments are not overly aggressive. Second, insurers cannot rate retroactively to cover past losses. Finally, although liability insurers have had stock market losses, who hasn’t? Several leading investment analysts have noted that liability insurers are conservative investors, with the majority of their investments going into the relatively stable bond market and only 10 percent into the stock market. This contention is also

shortchanged by a very telling trend: liability insurers’ annual losses have been so severe that they are leaving the market in droves. It is difficult to get exact numbers, but in Illinois, for example, there are now fewer than 10 insurers writing liability policies, some or most of which are limiting policies to low-risk physicians.

Adding to the ruckus is the increasing practice of “defensive medicine,” which the U. S. Department of Health and Human Services approximates at a cost of \$28–48 billion, annually. Opponents argue that the extent of defensive medicine is grossly exaggerated by health care providers to strengthen their case in favor of liability reform.

“Of course, it’s happening,” counters Dr. Block. “It’s happening some in cardiology practices. It’s definitely happening in the ER. ... they have been put in the position of doing a ton of extra tests and it leads to more costs. I joke that a CT scan has become part of the admission panel in the ER.”

Lawsuit abuse has been particularly problematic in Louisiana, where the American Tort Reform Association ranks New Orleans and its environs as one of the top ten “judicial hellholes.” The situation has certainly fueled the practice of defensive medicine there, explains Fred G. Kushner, MD, from the Heart Clinic of Louisiana. His nine-physician practice has seen its liability rates jump \$100,000 over the past two years. [Despite Louisiana’s having a \$500,000 cap on noneconomic damages since 1975, other reforms needed to work in conjunction with a cap, like those in the bill passed by the U.S. House, have not been enacted. See Figure 1.]

“Anybody who says that defensive medicine is a myth is grossly misinformed,” Dr. Kushner says.

The most extreme form of defensive medicine—not offering certain services or not performing certain treatments—is also becoming more commonplace. At the Little Rock practice of Randal F. Hundley, MD, governor-elect of the ACC Arkansas Chapter, physicians have changed how they manage patients on warfarin who live in rural areas. In the past, these patients typically had their blood drawn by their family physicians, with the results faxed to the practice.

“Now, we say that if we are to be responsible for

Farmers, the most recent major insurer to depart the liability insurance market, lost more than \$100 million in 2002. Overall, liability insurers paid out \$1.53 for every premium dollar received in 2001. After accounting for investment income, \$1.35 was paid out for every premium dollar received.

managing your warfarin, you're going to have your blood drawn in our office," Dr. Hundley explains. For patients in rural areas, regular trips to Little Rock are a significant hardship, if not an impossibility, and may mean that a physician with less experience in cardiovascular medicine will have to assume responsibility for that aspect of their care.

Taking to the Airwaves

The physician community, perhaps, has been more proactive on liability reform than it has on any other issue in recent memory, from coordinated e-mail and phone campaigns to marches on state capitols and job actions (see p. 4). Despite some success at the state level, a federal solution remains elusive.

As a result, the ACC has joined with six other specialty societies to form a coalition called Doctors for Medical Liability Reform (DMLR). The coalition is preparing to launch a multi-pronged public campaign to educate the public about the need for medical liability reform and to urge federal legislators to enact a strong medical liability reform bill. The College has committed \$500,000 to the campaign. While part of that commitment will be met with existing funds, the College is relying on strong response from Fellows, who in their annual membership notices—sent out in early October—can elect to make a nominal contribution toward the campaign.

"I realize that not all states have been affected by this problem. But in one way or another, we are all being affected," ACC President Carl J. Pepine, MD, wrote in a letter that accompanied ACC members' dues notice. "The liability crisis is serious and only getting worse. It is imperative that we join our physician colleagues to fight this nationwide problem."

ACC Political Action Committee Vice Chair Jerry Kennett, MD, represents the ACC in the DMLR. He says the new campaign will be aggressive and different from anything the College has engaged in before. It will involve TV and print ads, most of which will target specific states and even specific legislators. "With an election year approaching, this is a new ball game," he says. "We've got to change tactics if we're going to have an impact."

In Missouri, Dr. Kennett's home state, the ACC Chapter played a critical role in convincing the state legislature to pass a liability reform bill that included many of the reforms the College advocated, including a noneconomic damages cap. Unfortunately, the bill was vetoed by Governor Bob Holden. So, for Missouri—like Washington, Illinois, and many other states—the only solution appears to be a federal one.

"We all know colleagues who have had their liability premiums go through the roof, or who

can't even get a quote—even if they've never had a claim brought against them," Dr. Kennett says. "We've got physicians quitting their practices at the peak of their careers and patients losing access to care because of this crisis. We have an obligation to do everything we can to stop it in its tracks." ■

Figure 1. Provisions in "The HEALTH ACT" passed by the U. S. House of Representatives

Reform	Why
Limits the time a plaintiff has to file a health care liability action to three years	Ensures that 1) claims are brought before evidence is destroyed and 2) witnesses are available and memories are fresh
Ensures that a party named in a liability suit is only liable in proportion to his/her degree of fault, and considers other damage payments already received.	Ensures that damages are allocated fairly and that plaintiffs can't dig for "deep pockets."
Empowers courts to maximize patients' awards.	Ensures that an unjust portion of the patient's recovery is not misdirected to his or her attorney and limits incentives to pursue claims without merit.
Caps noneconomic damages at the greater of two times the amount of economic damages awarded, or \$250,000.	Ensures predictability and fairness in awards for difficult-to-measure damages such as "pain and suffering."
Allows states that have already enacted damages caps, whether larger or smaller than those provided under federal law, to retain such caps.	Ensures states' rights in area traditionally overseen by the states.
Allows money for future medical expenses to be paid periodically rather than in one lump sum	Ensures that plaintiffs receive damages in a timely fashion without risking the bankruptcy of the defendant.

Figure 2. Medical liability rate increases for all physicians, according to *Medical Liability Monitor* 2003 nationwide rate survey.

