

Runaway Train: Putting the Brakes on Medical Malpractice Myths

** Clifford Britt's article is based upon remarks prepared by the N.C. Academy of Trial Lawyers, presented by past president Burton Craige to the N.C. House Blue Ribbon Task Force on Medical Malpractice (November 10, 2003), and updated by data compiled by the N.C. Administrative Office of the Courts.*

by Clifford Britt



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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 some politicians and big businesses are telling you that juries can't be trusted to decide damages in medical malpractice cases; that doctors and hospitals—unlike everyone else—should not be held accountable for the consequences of their negligence. Special interests pushed the legislature to enact radical measures that strip North Carolina citizens of their right to trial by jury. Fortunately, the leaders in our legislature looked carefully at the facts first.

How has this issue become a runaway train? The campaign for “malpractice reform” is fueled by six myths:

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. Based on those statistics, 1,200 to 2,800 North Carolinians die in hospitals each year as a result of medical mistakes. 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. At that rate, approximately 18,000 North Carolinians are injured by medical mistakes in hospitals each year.¹

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 645 medical malpractice suits in

2003—only a fraction of the thousands injured or killed by malpractice. And, while North Carolina's population is growing rapidly, the number of malpractice suits has stayed flat, averaging 609 per year since 1998, and declining by 12.6 percent from 2003 to December 2004.² (Table 1.)

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. In addition, 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. 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 less than 20 percent of the time.³ In the rare case when 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.

Data from the state Administrative Office of the Courts indicate that 3,700 med-

Table 1

Year	Medical Malpractice Cases Filed	Change from Previous Year	% Change from Previous Year	Civil Filings: Superior and District Courts**
1998	556	N/A	N/A	200,107
1999	586	30	5.4%	202,994
2000	627	41	7.0%	215,651
2001	678	51	8.1%	219,424
2002	608	-70	-10.3%	216,778
2003	645	37	6.1%	213,541
2004	564	-81	-12.6%	—

erage collected rate per insured in 2002 was \$9,192.¹¹ And premiums charged by other companies are even lower. Last spring, the North Carolina Department of Insurance released comprehensive data demonstrating that the average earned premium per physician in 2003 was only \$10,634.¹²

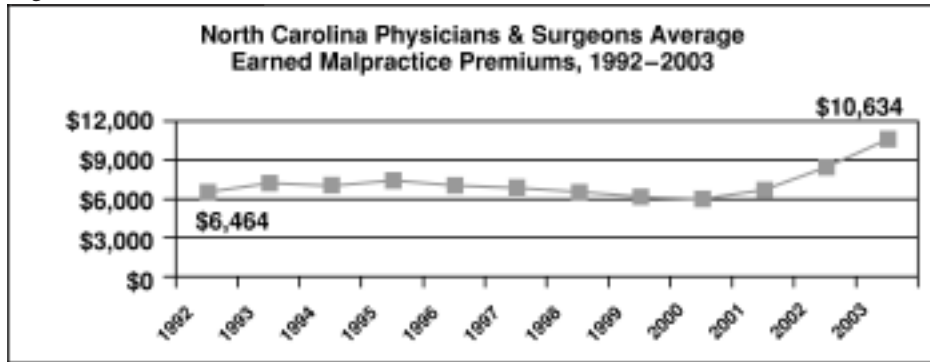
Myth No. 4: “Doctors Are Leaving North Carolina Because of Malpractice Lawsuits and High Insurance Premiums”

The number of physicians per person in North Carolina has risen steadily, from 12 doctors per 10,000 in population in 1979 to 16 per 10,000 in 1990 to 20 per 10,000 in 2003.¹³ (Figure 2.)

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 percent per year.¹⁴ During that same period, the number of obstetricians practicing in North Carolina increased from 747 to 937—an annual rate of increase of 4.2 percent.¹⁵ In other words, the number of obstetricians in North Carolina has grown almost twice as fast as the state’s population. (Figure 3.)

Recent studies by the Government Accounting Office (GAO) 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

Figure 1



ical malpractice lawsuits were filed between 1998 and 2003.⁴ This represented less than 0.3 percent of all civil cases (211,416) filed in North Carolina during that period. Of these 3,700 cases, roughly 2,772 had been resolved as of the beginning of 2004. Among the resolved medical malpractice lawsuits, 101 had reached a jury trial (3.6 percent of resolved cases). Only 22 of those cases (21.7 percent) were decided in favor of the plaintiff. The median jury award was \$300,000, with only three verdicts of more than \$1 million.⁵

If there were any substance to the claims of “runaway juries” and “outrageous verdicts,” one would expect to hear examples cited by lobbyists for malpractice “reform.” Their silence speaks volumes. In North Carolina, a jury only awards substantial damages to a malpractice plaintiff if there is powerful evidence to support the award.

Myth No. 3: “Malpractice Insurance Premiums Are Skyrocketing”

From 1989 through 2002, Medical Mutual of North Carolina, the largest writer of malpractice insurance in the state, increased its base premium rate 3.8 percent per year.⁶ During that same period, the cost of medical services, including physicians’ services, increased at an average annual rate of 5.3 percent.⁷ Thus, victims of malpractice faced

sharper increases in medical costs for treating their injuries than doctors faced in their liability premiums. (Figure 1.)

In 2001 and 2002, when the stock and bond markets dropped sharply, insurers raised premiums to compensate for a lower return on their investments.⁸ In 2002, Medical Mutual increased its premiums by 12 percent.⁹ That increase was modest in comparison with premium hikes consumers faced for property, casualty, and health insurance.¹⁰

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 av-

Figure 2

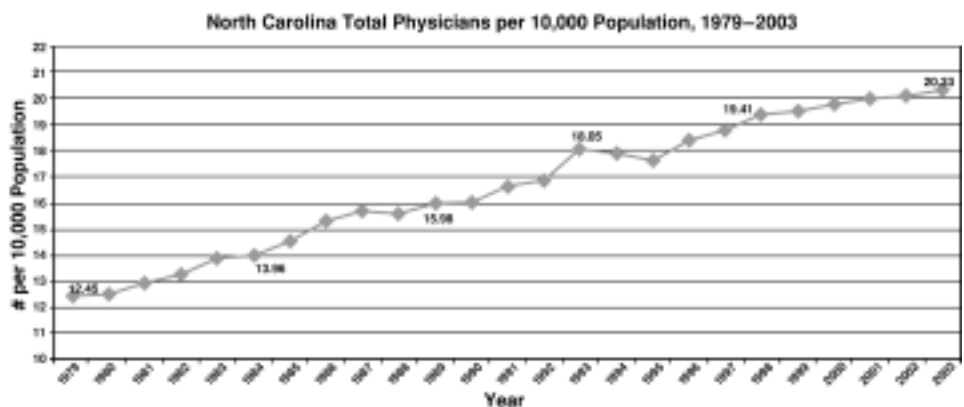
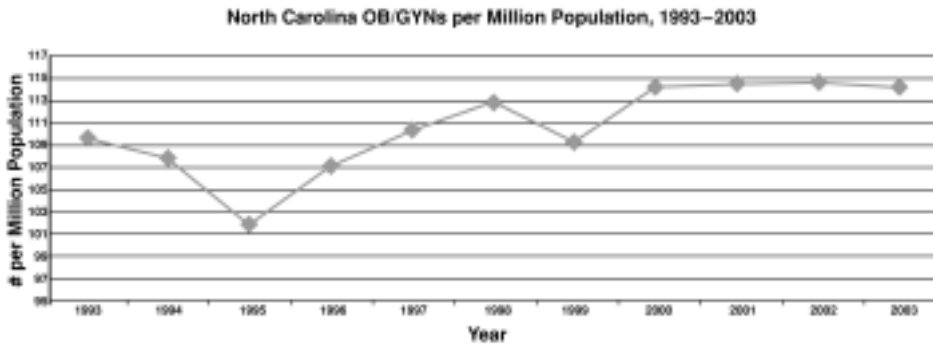


Figure 3



factors in addition to malpractice pressures that affected the availability of services.”¹⁶ 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 in population increasing from 221 in 1991 to 257 in 2001, an increase of 16.3 percent.¹⁷ At the same time, the number of physicians per 100,000 in population in non-metropolitan North Carolina grew almost twice as fast, from 96 to 125, a 30.2 percent increase.¹⁸ Thus, the facts demolish the claim that the General Assembly needs to enact radical malpractice “reform” to stem an exodus of doctors from rural North Carolina.

Lobbyists for the insurance industry say that North Carolina will attract more doctors if we copy the malpractice “reforms” that California enacted in 1975. Those “reforms” drastically curtailed patients’ rights to pursue malpractice claims. 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 non-metropolitan areas from 1991 to 2001, the number of physicians per capita grew twice as fast in North Carolina as it did in California (30.2 percent v. 15.2 percent).¹⁹ From 1991 to 2001, while the number of physicians per capita in metropolitan areas increased 16.2 percent in North Carolina, the rate of growth in California was only 1.8 percent.²⁰

Doctors are flocking to North Carolina, and abandoning California. Why should we follow California’s example?

Myth No. 5: “Doctors Are Practicing 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.”²¹ 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.”²² Moreover, managed care has significantly mitigated the effect of defensive practices: in today’s managed care environment, insurance companies will pay only for procedures of proven efficacy.²³

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.”

Myth No. 6: “Non-economic Damage Caps Will Lower Premiums”

Advocates for a cap on human losses (“non-economic damages”) point to the experience in California, where a \$250,000 cap was enacted. However, a closer examination reveals that California’s relative success in limiting medical liability insurance costs is not due to the cap on damages, but to insurance reform. Following the 1975 enactment of cap legislation known as

the Medical Injury Compensation Reform Act (MICRA), California’s total liability insurance premiums rose 190 percent over the next 12 years (a 40 percent increase when adjusted for inflation).²⁴ Then in 1988, California voters approved Proposition 103, an insurance reform measure that gave the Commissioner of Insurance greater power over rates and mandated hearings to justify large rate increases. Since then, California’s medical malpractice insurance costs have stabilized, and in 2001, stood 2.4 percent lower than the year Proposition 103 was enacted (34.9 percent lower, when adjusted for inflation).²⁵ Thus, California’s stable rates resulted from insurance reform, not caps on damages. (Figure 4.)

Looking Behind the Rhetoric of Malpractice “Reform”

In recent years, managed care companies have imposed more stringent restrictions on health care providers, curtailing their ability to generate revenues. Reimbursement rates for Medicare and Medicaid have been stagnant, while the cost of providing health services has increased. Many health care providers in North Carolina, including hospitals and nursing homes, are feeling the pain of flat revenues and rising costs. That pain has little to do with malpractice premiums, which account for a tiny fraction of total revenues.²⁶

From 2000 to 2002, the stock and bond markets declined sharply. Medical malpractice insurers, who relied heavily on investment income in the 1990’s to keep premiums low, then raised their premiums to compensate for investment losses. Health care providers, having benefited from unrealistically low premiums for a decade, were unprepared for the market-driven increases they experienced in 2001 and 2002. In an era of stagnant revenues, the premium hikes were more difficult to absorb.

If we look beyond the tort reform rhetoric, the root of the problem experienced by some health care providers is not a “litigation crisis.” Instead, they face the results of a temporary “hard” cycle in the insurance market coinciding with a period of restricted growth in revenues. Legislative solutions must target the real problem, not the myths invoked by the insurance industry.

What Can Be Done?

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

Reform and Strengthen 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 payments are made to settle three or more malpractice claims against a particular physician, the Board should be required to conduct an investigation of the physician and publicize its findings.

Implement Effective Insurance Regulation

North Carolina should enact legislation similar to California's Proposition 103. 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 percent.

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.

Give Targeted Tax Credits

Doctors in critical specialties practicing in poor, underserved communities should receive tax credits for their premium payments.

Increase Medicaid Reimbursements

The legislature should help community hospitals and nursing homes by increasing Medicaid reimbursements to more accurately reflect the cost of providing services.

The legal system promotes patients' safety by holding doctors, hospitals and nursing homes accountable for their mistakes. The insurance industry and other special interests have proposed radical measures to prevent patients from seeking compensation for their injuries. Dismantling the mechanism that protects patients' 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. ■

¹ LINDA T. KOHN, JANET M. CORRIGAN AND MOLLA S. DONALDSON, EDS., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM*, (Institute of Medicine, National Academy Press, Washington, D.C.) (2000); *Medical Misdiagnosis*, PUBLIC CITIZEN'S CONGRESS WATCH, January 2003; THE COMMONWEALTH FUND, *QUALITY OF HEALTH-CARE IN THE UNITED STATES: A CHARTBOOK*, 2002; The N.C. Department of Health and Human Services State Center for Health Statistics issued the "2000 County Health Databook" indicating that there were 896,809 hospitalizations in that year. When an error rate of two percent is applied to this statistic, it indicates approximately 17,936 medical errors.

² N.C. Administrative Office of the Courts; 2004 data through 7 December.

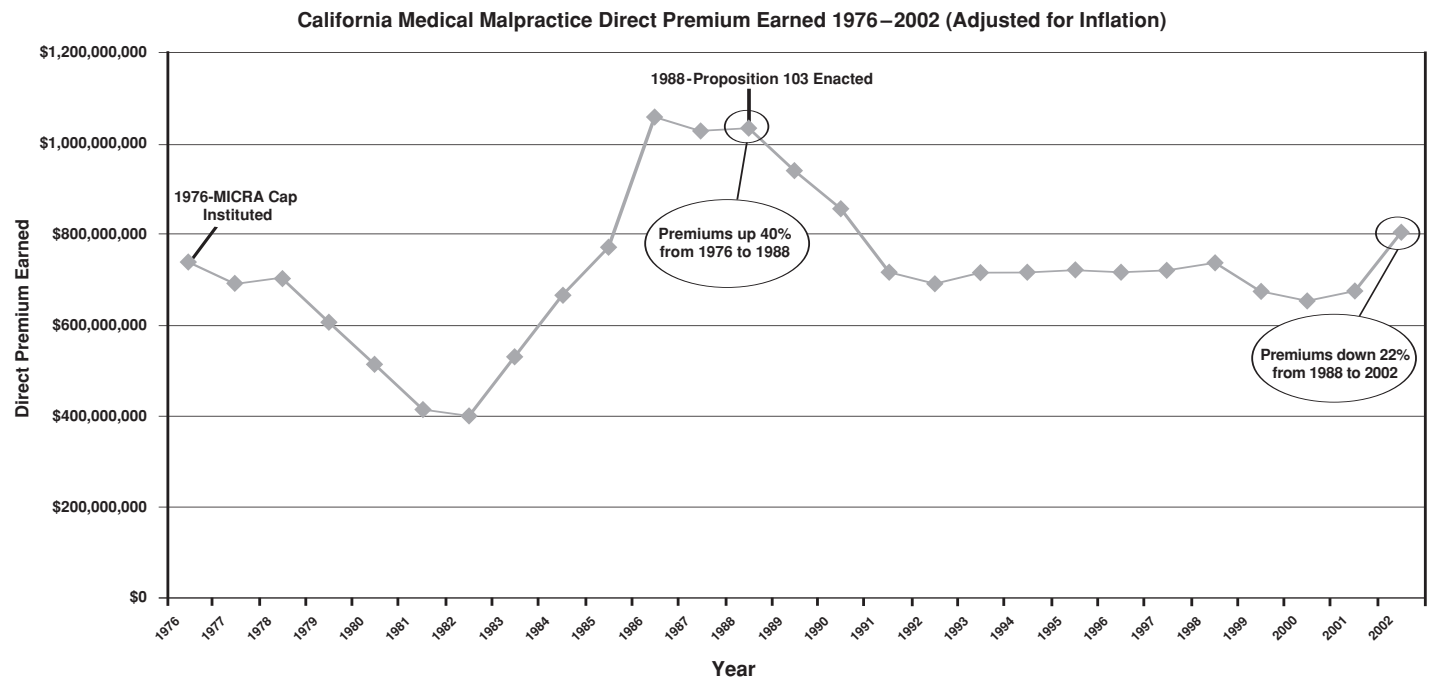
³ N. VIDMAR, *MEDICAL MALPRACTICE AND THE AMERICAN JURY* (University of Michigan Press, 1995). (2) Peeples, Harris & Metzloff, *The Process of Managing Medical Malpractice Cases*, 37 WAKE FOREST LAW REVIEW 877, 887-88, 899 (2002) (Table 6) (plaintiff won 16.7 percent of cases tried).

⁴ N.C. Administrative Office of the Courts.

⁵ The N.C. Academy of Trial Lawyers contacted Clerk of Court offices in the counties where each lawsuit was filed in order to obtain jury verdict and award amount information.

⁶ Annualization of data in Medical Mutual Insurance Company of North Carolina's *Rate/Rule Filing No. NC-R-020004, Exhibit 6*, with N.C. Department of Insurance, August 18, 2002.

Figure 4



⁷ UNITED STATES BUREAU OF LABOR STATISTICS, CONSUMER PRICE INDEX – ALL URBAN CONSUMERS, MEDICAL CARE SERVICES 1989-2002.

⁸ Christopher Oster and Rachel Zimmerman, *Insurer's Price Wars Contributed to Doctors Facing Soaring Costs*, WALL STREET JOURNAL, June 24, 2002.

⁹ Medical Mutual Insurance Company of North Carolina's *Rate/Rule Filing No. NC-R-020004, Exhibit 6*, with N.C. Department of Insurance, August 18, 2002.

¹⁰ Joseph B. Treaster, *Insurance Rates Are Rising Sharply Across U.S.*, NEW YORK TIMES, October 24, 2002; Albert B. Crenshaw, *A Move to Halt the Premium Seesaw*, WASHINGTON POST, June 24, 2002.

¹¹ Tillinghast-Towers Perrin actuarial memorandum included as exhibit in Medical Mutual Insurance Company of North Carolina rate filing with the N.C. Department of Insurance dated August 30, 2002, No.-R-030001.

¹² N.C. Insurance Commissioner Jim Long, Testimony before the Senate Select Committee on Insurance and Civil Justice Reform, May 21, 2003.

¹³ U.S. CENSUS BUREAU, STATE POPULATION ESTIMATES – NORTH CAROLINA 1979, 2001; NORTH CAROLINA HEALTH PROFESSIONS DATA SYSTEM, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

¹⁴ NORTH CAROLINA HEALTH PROFESSIONS DATA SYSTEM, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

¹⁵ *Id.*

¹⁶ Government Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, 13 (August 2003).

¹⁷ Government Accounting Office, *Physician Workforce*, Appendix III (October 2003).

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.* and chart provided to the House Blue Ribbon Task Force on Medical Malpractice, November 10, 2003.

²¹ GAO, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, 26-30 (August 2003).

²² *Id.* at 26, 27.

²³ *Id.* at 27.

²⁴ NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, REPORT ON PROFITABILITY BY LINE AND BY STATE – CALIFORNIA, 1976 and 1988. Inflation adjustment based on U.S. BUREAU OF LABOR STATISTICS, CONSUMER PRICE INDEX – ALL URBAN CONSUMERS, ALL ITEMS 1976-2001.

²⁵ *Id.*

²⁶ Based on testimony by Mr. Ted Goins and Mr. J. Luckey Welsh, Jr. to the Senate Select Committee on Insurance and Civil Justice Reform, May 28, 2003. Goins stated that premiums for Lutheran Services for the Aging had increased to \$550 per bed. For a Medicaid reimbursement (the lowest rate possible) of \$43,800 per bed, the liability cost is 1.26 percent. Welch stated that the premium for Southeastern Regional Medical Center was \$1.85 million, or 1.52 percent of the hospital's \$121.7 million operating budget.

Caps on Non-economic Damages Only Add to Life of Suffering

Eric Hedgepeth was a little wild as a teenager, though no more so than most. He enjoyed lifting weights and going out with girls. Before the medical negligence that changed his life forever, he had just finished the 10th grade and was looking for part time jobs.

On July 24, 1987, Eric drove himself and his mother to what was then the Medical College of Virginia Hospitals to have his tonsils removed. His mother, Janice Hedgepeth, had saved \$2000 for the routine procedure.

Hours after he was led away, Janice Hedgepeth was told that doctors were not sure what had happened; Eric had stopped breathing, his heart had stopped, and he was now in intensive care in a coma. He remained in a coma for two weeks, then spent eight months in a cerebral palsy center at the Children's Hospital in Richmond. It soon became apparent that Eric would never recuperate.

The family's lawyer, John W. Moore III, filed suit in 1988 naming a succession of failures and mistakes. A leading anesthesiologist in Los Angeles wrote that he had never heard of a tonsillectomy patient being given so much anesthetic. The narcotic was so strong that Eric stopped breathing, and the oxygen loss killed parts of his brain. Later, in the recovery room, the way he was positioned further inhibited his ability to breathe, according to experts. Further, a device used to measure oxygen levels in the blood, though widely available, was not used on Eric.

Virginia's limits on recovery for pain and suffering make it the strictest state in the country for injured patients who try to get help through the court system. It took 17 months after filing suit to reach a settlement of \$1 million, which was the maximum amount available to victims of medical negligence in Virginia at the time.

According to court records, Eric's attorneys spent 3,000 hours on his case. After paying her attorneys and for expensive expert testimony, Janice Hedgepeth put the rest of the settlement money into a trust for Eric, a trust that is rapidly being depleted. Janice Hedgepeth quit working and moved to rural North Carolina to care for her son—life planners estimated hiring care would cost upwards of \$120,000 a year. Eric's wheelchair, which must soon be replaced, costs \$5,000. Tens of thousands of dollars go for the incidental medical needs of someone who has been catastrophically injured—diapers, doctors' visits—and for food and daily expenses.

Even economic damages are hard to quantify for someone like Eric, who was essentially a child when he was injured. He had only worked a few construction jobs. His potential earnings were speculative.

But the insurance industry and physician groups want North Carolina to set an arbitrary limit of \$250,000 on the damages someone like Eric could recover for his non-economic losses. Seventeen years later, Eric is now 34 years old. He can't talk or walk. He can't see. His hands and arms are drawn in toward his body, his fingers stiff. He can't use the toilet, wipe his mouth, brush his teeth, or scratch an itch. And he suffers chronic pain and fatigue. He has been dependent on others for 17 years, and will require nursing care for the rest of his life. A neuropsychological assessment of Eric concluded that he acknowledged [by nodding] feeling depressed and suicidal, and strongly wished to die.

Non-economic damages compensate patients for very real injuries, whether or not they have substantial economic losses, such as a lost salary. The government should not usurp the function of the jury by capping non-economic damages at any amount. That would only add to the suffering many injured patients have already endured. ■