The struggle between politically active physicians and trial lawyers continues, with victories, losses and recoveries at the state level but no movement in Washington.

By Nathan Hall, Associate Editor

If America’s health care system were a patient, it would be the sort a clinician dreads: one who listens while you prescribe the best treatment course possible based on the latest available evidence, but questions your authority due to concerns raised by a person or group with absolutely no medical training.

Practitioners of all medical specialties may be familiar with this sort of situation and know how frustrating it can be when “evidence-based” strategies are either challenged or simply ignored. Those physicians who have gotten politically active encounter this frustration outside the exam room when they see the arguments put forth by trial lawyers and consumer groups arguing that there is in fact no medical liability crisis, that caps on awards for malpractice damages will do nothing to stop skyrocketing insurance rates, or that the “real” problem is rampant negligence and incompetence among physicians. Of
course, physicians have their own data proving the effectiveness of medical liability reform based on caps for non-economic damages, their own experiences with rising insurance premiums, and in many states anecdotes about colleagues restricting their services to avoid high-risk procedures or even closing their practices due to the high price of offering health care. The debates often resemble a direct contest between the strength of reason on each side.

This tug-of-war between doctors and lawyers for the hearts and minds of America’s health care patients is occurring simultaneously at the state and federal level. Depending on what state you’re in, the future could seem bleak, auspicious or stable, but it’s a chronic struggle with gains, losses, trade-offs, compromises and stalemates. In this article, we’ll look at some of the most active areas of the country in the medical liability crisis.

**Dunce Caps, Not Liability Caps, in DC**

The prospect was enticing, but many veterans of the medical liability reform movement found it hard to get too excited in May not to have brought to the nation. for $250,000 damages, limits on expert reforms, all of which have proven successful in Texas. measure failed to get even be debated by lawmakers.

It’s easy to say to say that caps aren’t the only possible solution to the medical liability crisis, but saying what could stand as a viable alternative is much harder. Nevertheless, politicians eager to win the support of physicians without losing campaign contributions from trial lawyers are looking for other solutions to the ongoing health care crisis. Both chambers of Congress took a look at the problem. The Senate’s Committee on Health, Education, Labor and Pensions met on June 22 and the Health Subcommittee of the
Committee of Energy and Commerce in the House of Representatives met on July 13, and advocates from both sides of the debate stated their positions at both events.

One alternative often touted in the Senate is the early disclosure and compensation model, where physicians are allowed (in fact, encouraged) to admit to patients that an unexpected adverse outcome occurred without this being considered an admission of liability. Some institutions have implemented such a policy with a degree of success, and a group called the Sorry Works! Coalition is trying to make this a more popular position in the reform debate. The idea forms the basis for the Medical Error Disclosure and Compensation (MEDiC) Bill (S.1784), which was recently introduced by Senators Hillary Rodham Clinton (D-NY) and Barack Obama (D-Ill) and described in NEJM 2006;354:2205-2208.

But Robert Surrick, Esq, Executive Director of the legal service Doctor's Advocate, says this proposal reads like it is taken straight from the trial lawyer’s playbook, as it assumes the problem originates from doctors committing many mistakes. The real problem, he says, is the volume of lawsuits slung against physicians, often with dubious cause. Mr Surrick notes that statically one-half (more than 10,000) of the physicians in his home state of Pennsylvania have been sued, but 85 percent of these cases ended in favor of the doctor. “This may seem good, but the doctors still go through five years of pain, agony and loss and have their insurance premiums raised even when they win,” he says.

When it comes to implementing health care reform without caps, Mr. Surrick says, “There’s one alternative that would work, and that’s to get these cases out of the court system.” He says having medical experts consider the merits of the case—as opposed to juries who are likely to be swayed more by tales of pain and suffering than abstruse facts in the medical literature—can go a long way towards creating a more reasonable award system.

Indeed, health courts were considered during the House discussions, with both advocates and opponents of the system delivering testimony. On the supporting side was Michelle Mello, JD, PhD, a professor of health policy and law at the Harvard School of Public Health, who said the idea of a court system shifted medical liability from one based on negligence to one based on prevention and encouraged the committee to consider implementing these at the state level through a series of federally funded pilot projects. On the other side of the debate was Joanne Doroshow, President and Executive Director of the Center for Justice and Democracy (a consumer advocacy group), who countered by saying that health courts would jeopardize plaintiffs’ right to an unbiased judge and jury.

Both debates for alternatives ended without a clear direction and few, if any, minds changed. In its statement to the Senate, the American Medical Association said it supports examining other options but remains committed to a federal legislation based on California’s MICRA. The low caps on non-economic damages this act implemented have kept the rate of increases for liability premiums far lower in the Golden State than the national average for the last 30 years.

Striking Paydirt in Texas

Those searching for a compromise may spend a lot of time exploring other options, but there is tangible proof that caps can work if they are put in place and firmly kept there. Texas was one of the wildest battlegrounds in the crisis, where quick-on-the-draw lawyers shooting for high awards had many physicians running for greener pastures in other states. But enough politically active physicians stuck to their guns in 2003 to get a $250,000 cap put on non-economic damages against health care providers (with another cap for cases against an institution and one for cases where multiple institutions are involved, making the maximum possible award $750,000). The physicians then rallied the citizens to include the changes into the state constitution by approving an amendment to support the caps. The initiative garnered 51 percent of the vote, making it a very narrow victory.

Since then, the state has seen an influx of new physicians. According to a May 2005 report from the Texas Medical Board, the state is the new home of many more specialists in high-risk professions, including 16 neurologists in the Houston medical community alone. In the spring 2006 newsletter the board reported an unparalleled growth in licensure applications, with only a few of these being from states affected by Hurricane Katrina or residents seeking a license to moonlight outside of the 80-hour workweek, and the board now needs 95 days to review each application.

Medical liability premiums consequently went from skyrocketing to sharply decreasing. The Texas Department of Insurance reported an average rate cut of 13.5 percent in 2005, and for 2006 the state's largest insurer, Texas Medical Liability Trust, cut its rates by five percent across the board. Overall, Texas physicians stand to save an estimated $49 million on their 2006 premiums according to data compiled by the AMA.

Houston neurologist Randolph W. Evans, MD was very active in the effort to get reform passed in his state, and now he's reaping the benefits. He's seen his premiums drop from $20,000/year to $11,500/year and many new specialists move into his neighborhood. As for the trial lawyers, he says he's heard many of them are considering practicing other areas of law.

The Texans may have won the war, but Dr. Evans says the physicians are still facing the fallout from the publicly waged battles. Trial lawyer groups tried to fight the caps by saying...
they would protect negligent physicians and encourage bad
doctors to come to Texas, and much suspicion remains among
the public. As a result, the state medical board seems to have
become more vigilant by getting much tougher on offenses.
Dr. Evans recounts one case where a physician was charged
$3,000 for delivering a medical transcription via a cell phone
while on a grounded airplane and several other instances where
little administrative errors led to big fines. “Some of these are
fines for trivial things, akin to jaywalking,” Dr. Evans says.
“Why are they getting slapped with fines instead of being edu-
cated?”

Although Dr. Evans says many Texas doctors feel the aggres-
sive medical board was a trade-off for caps, they’re still much
happier with the caps in place. And even though they need not
fear multimillion-dollar verdicts, they still practice cautiously.
“Having caps doesn’t mean we don’t have concerns about litiga-
tion,” Dr. Evans says. “It doesn’t mean we still don’t practice
defensive medicine.”

Hard Cheese for Wisconsin
The physicians in Texas fought hard to get their caps passed in
the state’s legislature and did not stop until it was written in to
the state’s constitution. Though this undoubtedly required a
great deal of work, the effort is essential. An incident to the
north shows that the protection provided by caps can be lost
with a single vote—particularly if that vote comes from a judge
in the state’s capitol.

In 1995 the physicians of Wisconsin received a $350,000
cap on non-economic pain and suffering damages, which was
adjusted for inflation to $445,775 in 2005. This gave it a dis-
tinction of being one of the six white “Currently OK” states on
the AMA’s medical liability map. While the system was not
touted as the model for reform like California’s MICRA, it was
regarded as adequate protection for physicians. The state
earned a reputation as a sanctuary for those who yearned to
practice free from the skyrocketing premiums common imme-
diately to the south in Illinois as well as other states in perpet-
ual crisis such as Pennsylvania, Ohio and Washington. But
these refugees and the native physicians received a rude awak-
ening in July 2005, when the Wisconsin Supreme Court decid-
ed in a 4-3 ruling that the caps were arbitrary and violated the
state’s equal protection clause.

“Depending on your political leanings, that could be called
legislating from the bench,” says Mark Belknap, MD, an
internist with a satellite office of the Duluth Clinic in Ashland
and the immediate past president of the Wisconsin Medical
Society. He led his organization in the battle to get the caps
reinstated along with the state’s hospital association and other
concerned groups. They took a proposal to reinstate the caps at
almost the same level to Madison that passed through the leg-
islature, but Governor Jim Doyle vetoed the bill on the
grounds that the caps were too similar to the ones already
struck down and would only be struck down again in another
court decision.
Faced with this setback, the Wisconsin physicians began to rigorously pursue a way to get caps put back in place. They raised public awareness of the potential crisis in the local media (to see the materials used in this campaign, go to www.keepdoctorsinwisconsin.org), created an activist network of concerned patients and developed a solution the governor would find more agreeable that could still hold malpractice premiums down. Meanwhile, trial lawyers were winning multimillion-dollar verdicts for pain-and-suffering damages in several publicized events.

In February the physicians were back before the legislature, this time with a new deal. They presented the results of a study from Pinnacle Actuarial Resources that compared how caps on non-economic damages were linked with available, affordable and stable health care for the people. More specifically, it showed a correlation of low medical costs and easy access to health care for states with low ($250,000) to medium ($550,000) caps as well as how having a cap of $1,000,000 or more was effectively the same as no cap at all. After this report was presented, the physicians made a request to get caps again, but this time with the limit set at $750,000. “It was more of a compromise that we thought would be more reasonable and less arbitrary than the old caps,” says Dr. Belknap.

The measure passed through both houses of the state legislature in March, but everyone was uncertain about what Gov. Doyle would do until he clicked his pen and signed the bill into law. The medical community rejoiced, the hospital associations publicly voiced a sigh of relief, and lawmakers impressed by the political advocacy spoke glowing of the compromise. However, the president of the Wisconsin Academy of Trial Lawyers vowed in a statement released to the media to legally challenge the legislation.

Dr. Belknap says it’s hard to say how effective the new caps will be and it may be years before the effects are apparent, particularly since it still remains to be seen what will happen to many of the huge awards given in the time between caps. “The thought among the Wisconsin medical community is that the medical liability premiums will rise gradually as opposed to the skyrocketing rates seen in crisis states,” he says. “We think it will have an effect for the better.”

**Sad Songs in Nashville**

Republican Senator and physician Bill Frist may be one of the biggest proponents of medical liability reform in Washington, but for his constituents in Tennessee the situation has gone from bad to worse—or, more specifically, from “showing problems signs” to becoming the 21st state “in crisis” on the AMA’s map. Gary Zelizer, Director of Government Affairs for the Tennessee Medical Association (TMA), says the physicians reacted to their new classification with resignation. “We knew we were there, it was just a matter of time before the AMA recognized it,” he says. “It’s been on our screen now for four years.”

Mr. Zelizer says the past several years have not been kind to the Tennessee medical community. Many obstetricians and gynecologists closed, moved or restricted the services offered in their practices due to liability fears. Each passing year came with double-digit rate increases in liability premiums. And graduates from the state’s medical colleges sought work elsewhere, with no one coming in to offer care to the mostly rural counties without neurosurgeons, orthopedic surgeons or emergency physicians.

The TMA tried to effect change in 2004, when the state’s general assembly organized a joint committee to look at the issue. Even though trial lawyers dominated the proceedings, Mr. Zelizer says the physicians and their advocates did what they could to make their point known among all the contradictory data. “I know we put some information out there we thought was compelling,” says Mr. Zelizer. Ultimately, the committee did nothing more than make it mandatory for medical liability insurers to report their payments, claims and premiums to the state. “There’s nothing wrong with that, but we weren’t going to let that deter us from raising attention to the problem,” says Mr. Zelizer.
Just before Tennessee officially became a crisis state, the TMA began getting its members active. In December of 2005 the organization sent the word out to physicians that they needed to get more involved if there was to be any change, and in January 2006 they held a town hall meeting in Nashville where more than 500 physicians were bussed in from throughout the state to discuss the problem. Later that day, TMA delegates met to endorse a medical liability reform campaign with a set framework, including a way to receive donations to fund its activities.

Now medical liability reform is the number-one item on the TMA's agenda, and it is backed by a coalition of more than 50 groups, including managed care providers, to endorse comprehensive reform. Mr. Zelizer says a steering committee is leading this group's effort to raise public awareness of the liability crisis and have them think about what it means to them. One of these efforts is to send targeted advertisements to key districts during election time. Since the coalition cannot endorse a candidate directly, it is trying to get the public thinking about how the candidates vote on these issues when considering the names on the ballots.

When raising awareness, whether it's to the public or to politicians, Mr. Zelizer says the coalition tries to make it clear the issue isn't just about premiums. Rather, it emphasizes the lack of access to health care and high costs of medical services caused by the crisis. He also says the coalition makes it clear that caps will cut down on defensive medicine, which even the trial lawyers acknowledge exists. "Many physicians admitted up front that caps would change the way they practice," he says.

Mr. Zelizer says the medical association did not push for statewide reform legislation in 2005 because there was no foundation in place to effect change. In 2006 the association, with the help of the coalition, created a single omnibus bill that would have put caps on malpractice damages, but the situation was still pessimistic and few were surprised when it was shot down by the primarily Democratic legislature in March. He says the organization is trying again with a new bill, this one signed by four Democratic co-sponsors with a fifth who's promised to sign and a sixth the association they are hoping will agree to put his name on the bill.

Tilling the Soil in Ohio
Tennessee is fighting hard to get caps re-enacted in its state, but it may be years before the politically active physicians reap the benefit of their labor. This would be particularly true if caps in the form of a bill passed by the legislature are all they get. The physicians in Texas went the extra mile by getting their caps put into an amendment to the state constitution, which makes them immune to a state Supreme Court challenge. In Ohio, physicians and insurance companies are all too aware of how easy it would be for them to lose their caps.

Ohio Governor Bob Taft signed a bill implementing $500,000 caps on non-economic damages in January 2005, but a year later the state was still listed as being "in crisis" on the AMA's map. At present the state's legal system is still trying to figure out how to interpret the caps. Tim Maglione, Esq, Senior Director of Government Relations for the Ohio State Medical Association (OSMA), says, "We know of 120 cases in the lower courts that are challenging aspects of tort reform, but so far none have come out of the state courts."

This is not to say the caps have been ineffective. Data compiled by the OSMA shows a correlation between the passage of limits on non-economic damages and the total rate changes for the top five medical malpractice insurance companies. In the years before the caps (2001-2004) premiums increased anywhere from 20 to 30 percent each year, but in 2005 the increase was only 6.7 percent and in 2006 the rates went down an average 1.5 percent. "The good news is that the market is stable," says Mr. Maglione. "The trend line is going in the right direction." He says a state Supreme Court verdict in favor of the caps may help reduce the caps even further.

How the caps have affected health care in Ohio still remains to be seen, and Mr. Maglione says the answers will be in soon. The OSMA is "going to the field" and surveying practitioners to see the impact caps have had at the practitioner's level. The goal, he says, is to benchmark the current situation and compare it to data from previous years to get a better picture of change. "The sense is that the medical liability situation is better," says Mr. Maglione. "While it's still very expensive to practice here, the year-to-year expenses have become stable."

Pulling for Change
It's not hard to picture a tug-of-war between two professions when thinking about the struggle for medical liability reform. The stories from various states show how victories are sometimes followed by defeats, how losses can be quickly recovered, and, in the end, any change that occurs comes from many hands pulling in the same direction against an opposing force with its feet dug deep into the ground. Although we may be tempted to let go of the rope at times, doing so would leave our colleagues and our patients in the lurches.

Those committed to health care may prefer to spend their time contemplating their patients' conditions, but during these tumultuous times it is important to use the strength of your expertise to strengthen the medical community as well as the patients it serves. Even when there is a setback, remember that a concentrated effort can shift the balance back toward your side again. PN