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## Private Responses to the Crisis

Joseph Murphy  
*St. Joseph Hospital*

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## SESSION 2: PRIVATE RESPONSES TO THE CRISIS

PROF. BLUM: To give us the physician perspective, I will turn the podium over to Dr. Murphy.

DR. MURPHY: Thank you. I will discuss the physician perspective [of the medical malpractice crisis] with a focus on balancing competing demands. I am in private practice, general internal medicine and geriatric medicine. I have been in practice over thirty years. I am [a] solo [practitioner]. Times have changed a lot for me.

I have been involved in the socioeconomic aspects of medicine since I was a medical student. I have remained involved with the various aspects of patient care, quality, and safety during that long time. It is very frustrating. I heard some of the angst of the individuals who gave their excellent presentations prior to me.

It's a very difficult thing to face some of the problems that we have. It's difficult because some of them seem so overwhelming. However, with the good work of the Institute of Medicine, Leapfrog, and the Joint Commission, it seems like they have a handle on it.

I grew up with a lot of my patients. Their grandmas started with me thirty years ago, and then I saw their children, and then I saw grandma's grandchildren. It's a very rewarding thing to grow along with families in life. [A]s we say in geriatric medicine—geriatrics and aging is a common pathway, a common journey. As I age, I can see and look back at all the wonders of medicine.

As far as our subject matter is concerned, when I started my practice in 1969, things were pretty carefree. I was excited, dying to get out there and naturally cure the world and change medicine all by myself. Then the 1970s came along and a lot of insurers left Illinois. Those were the issues of the cycle that was mentioned by our first speaker, the first cycle in my lifetime. MICRA, the tort reform in California, was enacted in 1975.<sup>1</sup> We had a pretty good bump in our premiums; then things quieted down a little bit.

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1. MICRA (commonly referred to as "Medical Injury Compensation Reform Act of 1975," contains five statutes), CAL. BUS. & PROF. CODE § 6146 (West 2003); CAL. CIV. CODE §§ 667.7, 3333.1(a), 3333.1(b), 3333.2 (West 2003).

Then in 1980 things started to rev up again in Illinois. Increased malpractice issues, changes in the law in 1984, all kinds of lawsuits were filed to get in under the wire in order to preserve the lawsuits. Currently, we have yet another crisis. It's a crisis to me—as an individual practitioner—that without any lawsuits, or any claims, or any problems, my malpractice insurance was raised forty-one percent last year for one million/three million. That is a pretty good chunk out of my income to run my office and to provide the things that my patients were accustomed to in my office. It makes it very, very difficult.

In the Jury Verdict Research, 2002 Edition, they said awards have increased 176% from 1994 to 2001.<sup>2</sup> The median award is \$1 million.<sup>3</sup> There have been a lot of changes. I mentioned earlier a world of change. The world of the physician has changed, whether you are in a solo practice, a group practice, or academic medicine, it really doesn't matter. The change is there. I can tell you it's across the face of medicine. It's not just one, or two, or a handful, or a portion. Many, many physicians are involved with the culture of fear.

I won't go into the statistics about how many cases are won, or what percentage, that was very nicely explained already. But I might point out that defense costs for cases, whether you call them frivolous suits or what have you, was an average of approximately \$40,000 [in 2001] to just defend the case and it never goes to trial.<sup>4</sup> In the Wirthlin worldwide poll in February of 2003 it talked about the increased cost and decreased access of our patients into the medical stream.<sup>5</sup> The Department of Health and Human Services in July of 2002, said that the litigation system as we know it today is a threat to quality medicine and it has increased the cost of medicine.<sup>6</sup> Tillinghast-Towers Perrin talked about the cost of the U.S. tort system.<sup>7</sup> The tort system increased costs by 14.4% in 2001.<sup>8</sup> It [the study]

2. See Press Release, Jury Verdict Research, Verdict and Settlement Study Released: No Change in Median Medical Malpractice Jury Award; Plaintiff Recovery Rate Up a Fraction (Mar. 20, 2003), at [http://www.juryverdictresearch.com/Press\\_Room/Press\\_releases/Verdict\\_study/verdict\\_study2.html](http://www.juryverdictresearch.com/Press_Room/Press_releases/Verdict_study/verdict_study2.html) (Mar. 17, 2004).

3. *Id.*

4. See U.S. DEP'T OF HEALTH & HUMAN SERVS. (HHS), ADDRESSING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE 12 (Mar. 2003), available at <http://www.aspe.hhs.gov/daltcp/reports/medliab.htm>.

5. Wirthlin Worldwide for the Health Coalition on Liability and Access, *February 2003 Poll Summary*, available at <http://www.hcla.org>.

6. HHS, CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 2 (July 2002), available at <http://www.aspe.hhs.gov/daltcp/reports/litrefm.htm>.

7. See generally TILLINGHAST-TOWERS PERRIN, U.S. TORT COSTS: 2003 UPDATE—TRENDS AND FINDINGS ON THE COSTS OF THE U.S. TORT SYSTEM (2003).

highlights that out of the one dollar for the patient, 21% goes to administrative costs, 19% goes to the plaintiff attorney, and 14% goes to the defense costs.<sup>9</sup> [W]hat does the patient get out of all this? When push comes to shove, the patient receives 22% in economic damages and 24% in non-economic damages. [O]ut of the dollar put in front of the patient, the patient gets only 46%. Perhaps there are other avenues within the collection of that dollar that could be reduced to increase the reward that we give to our patients. I have read that the cost of litigation in our country is starting to outpace the gross domestic product.<sup>10</sup> A Price Waterhouse Coopers study on litigation states that the cost of litigation led to a 7% increase in health insurance premiums [which represents \$5 billion of increased premium costs].<sup>11</sup>

There is a crisis in Illinois. There is a crisis for many physicians, and in other states too. Take Florida, for example, where not too long ago mammogram scheduling was done in twenty days. It now takes up to 150 days for a woman to get a mammogram because the radiologists that are doing most of the readings cannot get professional liability insurance.

Jury awards so far this year, there have been two that I know of, are over \$20 million. There is a newer threat out there—the class action suit. *Medical Economics* had a nice article on it.<sup>12</sup> A story telling of this new threat—there was a physician in Mississippi that faced ten lawsuits because he had prescribed Rezulin, a drug used for diabetes, later found to cause liver problems, and in a couple of cases, death. A class action suit was filed but in the ten cases that this one doctor faced, none of the patients were aware that it was a class action. They were unwittingly involved in it. There were some concerns about runners for certain attorneys to enlist patients to look for groups in these particular class action lawsuits. I think that the medical and legal profession both have a responsibility to let the public know with class action suits who will be involved.

We talked about the GAO earlier. The GAO sends some mixed signals. First, it says increased jury awards has caused the professional liability insurance (PLI).<sup>13</sup> That was the rationale. However, the PLI crisis is

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8. *Id.* at 1.

9. *Id.* at 17.

10. *Id.* at 9 (stating tort costs have increased by over a hundred fold while the GDP grew by a factor of thirty-five over the last fifty years).

11. PRICE WATERHOUSE COOPERS, *THE FACTORS FUELING RISING HEALTHCARE COSTS* 6 (Apr. 2002).

12. Dorothy L. Pennachio, “*I Didn’t Know I Was Suing You*”, 80 *MED. ECON.* 77 (2003).

13. U.S. GEN. ACCOUNTING OFFICE (GAO), *PUB. NO. GAO-03-836, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE* 9 (Aug. 2003), available at <http://www.gao.gov>.

localized, it's not widespread. The GAO studied nine states, five that had reported problems and 4 that had not.<sup>14</sup> Illinois was not studied. Instead, they checked a stable state, like California. There, of course the professional boards there are tempered by the MICRA legislation in that state.

Next, the GAO said that access was not significantly affected.<sup>15</sup> I can't see how they say that, because the doctors who are unable to make ends meet ends in their offices are cutting hours and are letting good employees go. [T]o say that that doesn't impact on access, to me, is just ridiculous.

Then there is the Employment Policy Foundation from Washington D.C., a private research firm.<sup>16</sup> [T]hey stated recently that the medical liability system in our country is costly, ineffective and does not protect the patients. That's sort of sad. After all the things we are doing to help our patients and help them when they are injured in our widespread, broad-based health system, they should be protected and they should be properly treated and awarded. It [the professional liability system] doesn't protect the patients.

The Employment Policy report stated that there is unlimited uncapped litigation.<sup>17</sup> What is the result of that? Well, you add \$97.5 billion a year to the cost of physicians, other providers and hospitals. You increase costs 12.7% for employers. You eliminate 2.7 million workers from the healthcare system. We are looking for nurses. We are looking for 2.7 million workers. It's staggering to think about.

Then there is a decrease of physicians in our country. If that isn't critical, I don't know what is. [W]e are losing a lot of the wealth of knowledge of our aging physicians, and I don't mean the ones that are no longer effective, but rather the physicians that are in the mature years of their life where they can be of great benefit to their patients in their private practices and their hospital.

[A]ll kinds of solutions have been discussed today, but I think one of them is probably worth talking about—the Texas Proposition 12, where the public voted for a constitutional amendment and they had the cap of \$250,000 on non-economic damages.<sup>18</sup> The Texas Medical Liability Trust PLI insurer has already gone on record that they will now rollback the

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14. *Id.* at 44.

15. *Id.* at 5, 7, 12, 16-24.

16. See the Employment Policy Foundation website, at [www.epf.org](http://www.epf.org).

17. Employment Policy Found., *Medical Malpractice Litigation Raises Health Care Cost, Reduces Access and Lowers Quality of Care*, ISSUE BACKGROUNDER, June 19, 2003, at 1.

18. Texas Proposition 12, HJR 3 was signed in the Texas Senate and House on May 20, 2003. See Texas Legislature Online, available at <http://www.capital.state.tx.us> (Proposition 12 is a constitutional amendment which makes damage limits constitutional and allows the legislature by statute to set non-economic damage limits).

premiums 12%.<sup>19</sup> President Bush has commented on what we all call frivolous litigation. The House already passed a \$250,000 cap. The Senate missed by a vote or two.

I also think patient safety legislation is excellent. There are many good things we can all learn and put to use in our practices, our hospitals, our offices, and our medical schools. What can we do in the hospitals? Well, the doctors must do things to improve quality in our hospitals, but they have so many things going, so many pressures, so many people pulling at their coattails that not enough of them volunteer to do the proper peer review. It could be a much better system. There are some states where the medical staffs pay the physicians to participate on these medical committees if they are giving up five, or six, or seven hours a week, just like they do for teaching our interns and our residents.

The medical staff is key to a lot of this [reform]; the relationship between the hospital and the medical staff is not as great as it should be. A lot of times the hospitals plan everything, do everything, and then it doesn't reach the medical staff until it's signed, sealed and delivered. Or they will hand you a fifty-page report and say, "What do you think of it? Can you let me know by tomorrow?" And that's called physician input. It should be at the top. Nurses should be involved at the top. These are the people that direct medical care in our hospitals.

Let me say a little bit about the profile of physicians. Physicians are getting depressed. Many of them have lost self-esteem, especially the ones that have been sued. They have lost power. We are losing autonomy and many have become frightened. We develop negative outlooks, and negative outlooks are not good for medicine. We are becoming defensive and that adds to the cost of medicine. We have the best doctors in the world, the best nurses in the world and we are driving them out of business. I know we have our complaints, our problems, things that we must do better, but we can cut down a little bit on the professional provider bashing that's constant or considered disruptive. If we spill a cup of coffee, we are considered a disruptive physician.

We are inundated and overwhelmed with increased premiums, with fear of lawsuits, unfunded mandates like HIPAA and 100,000 pages of Medicare regulations, EMTALA, and the National Practitioner Data Bank. How would attorneys, or anyone else, like to be put in some sort of databank if they made a mistake that the public could look at and review before they hired you as a lawyer? The state regulations, the Joint

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19. See the Texas Medical Liability Trust website, at <http://www.tmlt.org> (Mar. 17, 2004). See also Damon Adams, *Texas Tort Reform Vote Signals Lower Liability Rates*, AMNEWS, at <http://www.ama-assn.org/amednews/2003/10/06/gv111006.htm>.

Commission, Leapfrog, managed care, Medicare, on and on it goes. We are losing doctors. Seventy-two percent of Americans favor a cap on non-economic damages, according to a recent Gallup poll.<sup>20</sup> If it's that many people, why in the world can't we do something about it?

I put together [a survey] before I came here.<sup>21</sup> I gave it to my medical staff in their mailboxes last week. I put out about 200. I got back about fifty-five. Of the respondents, one-third were primary care doctors and the rest were specialists. Of those physicians, two doctors thought that the cost of PLI coverage was fair. Fifty-three said no.

Then we asked what group is primarily responsible for escalation; lawyers showed up fifty-three times or fifty-four times. [T]he next group in line was the insurers for PLI, and then the third highest group was the public. That's what the doctors think.

What are they going to do about it? Well, half of them said they would retire earlier than planned if their premiums went up again, which they probably will, or they may consider going to a geographic site that's friendly PLI-wise. Four even said they would go bare [no insurance coverage] and twenty-four said they would get more involved with lobbying in organized medicine for tort reform. Sadly, twenty of them said that they are going to decrease volunteering. They are not going to work as hard on medical staffs, hospital committees, teaching, or community service. That's a pretty sad thing to read.

What's going to happen down the line if we strike at the heart of our profession in healthcare in general? Are we going to have all of those folks to be able to provide those wonderful things?

I am going to close now with a paragraph from part of a healthcare essay I wrote for my medical staff. [T]his pretty much sums up how I feel and where we should be going. We had a rally at the Daley Plaza and our hospital sent a few buses. There were forty-five buses total. There were close to 3000 people in the plaza and when I saw a newspaper article that said 200 to 300 doctors showed up, I was disgusted. There were forty-five buses with about fifty people in each bus. That is significantly more than 200 to 300 people. In any event, my essay:

We are determined, we should be determined to reform the hellacious life sucking intolerable quagmire of the current tort system. We simply cannot take it any longer: the soaring premiums, the soaring jury awards, the loss of patient access, unconscionable attorney awards, physicians leaving the state and no longer doing complex procedures, or simply

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20. See Rick Blizzard, *Americans Support Malpractice Award Limits*, GALLOP POLL TUESDAY BRIEFING, Feb. 4, 2003.

21. See App. C, Professional Liability (PLI) Survey, compiled by Dr. Murphy.

retiring.

In closing, we must right the wrongs. Everyone in society must partake, everyone. Equitable tort systems must be created. We must preserve the moral and the vision of American medicine. We must keep our physicians in hospitals and out of courtrooms and we must continue to improve the quality and stature of medicine. Thank you, very much.

PROF. BLUM: At this point I am going to invite our speakers to come forward, as well as our additional moderator, Professor Mary Crossley. We have heard a lot of perspectives and now it's time to tie all of these together.

PROF. CROSSLEY: I wanted to take a minute before we start taking questions. Because we have heard some excellent presentations from the speakers from each of their own perspectives on private approaches to dealing with some of the issues with respect to the malpractice crisis.

There have been several mentions of the IOM report, *To Err Is Human*, but not as much mention of the second report, *Crossing the Quality Chasm*, which starts to look at solutions.<sup>22</sup> At least one of the focuses on the second report is thinking about how to develop systems of care that improve patient safety.

As I sat in the audience listening to these speakers this morning, I started to hear some of the really bottom up efforts to try to develop systems of care to improve patient safety, as well as to develop systems that improve the operation of the system for tort liability and also that try to improve the system to insure that there can be adequacy and stability of coverage for professional liability. One of the problems with this kind of bottom up approach is that it can become piecemeal. How effective can it be? How quickly can it address the problems?

Then there is the glimmer of hope that I heard when I started connecting some of the dots. There is some integration going on between the approaches at different levels. We hear about insurers that are starting to play a role in risk management. We hear about multi-specialty groups that are starting to develop captive insurance lines. We even hear about institutional providers who are starting to play a role in compensating victims of negligence before it ever goes to any sort of lawsuit.

So you start seeing some signs of integration. I know that integration was the hot topic in healthcare financing and delivery some years back, but maybe integration with respect to both victim compensation and provider coverage may be the wave of the future. At the same time, there is a clear

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22. INST. OF MED., *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* (2001).

lack of distrust among players on different parts of the systems.

The question I would throw out [to the panel] would be to what extent do panel members think that there is the potential for further integration and to what extent does a lack of trust inhibit that sort of integration and that approach towards both improving victim compensation and providing adequate coverage for healthcare providers?

MS. YOUNGBERG: I mentioned what I believed was an important need—more protective legislation around the disclosure subject. [T]here are some states that say if you disclose to a patient a medical error it is not discoverable. Also, I think the ability to protect information that organizations share for the purposes of error reduction [should be similarly strengthened through more protective legislation]. [T]he disintegration occurs because that information [number of medical errors] is often housed somewhere else in the organization and it doesn't get to be operational. I think integration will be facilitated if we have more protective legislation around what happens with data.

MR. MULCAHEY: Integrating risk management into most physician practices is really an uphill battle, not because it's not possible, but because large multi-specialty groups may not be able to afford the infrastructure to do that because it's a long-term commitment. Most physicians practice in small groups and there really is no infrastructure or dollars allocated to support the infrastructure. It may be episodic. If they have a bad claim, they run around and do something about it. I think integrating risk management in offices practices is a real challenge in this country.

PROF. CROSSLEY: Is it the kind of thing that insurers could help smaller groups do?

MR. MULCAHEY: Theoretically they could, but again, the small groups tend to jump carrier to carrier because they are looking for the lowest possible premium. A carrier might invest in a full-blown program for risk management for the small office. The next year the physicians may move the coverage to another carrier and the investment in risk management for the first carrier is lost. I don't want to be too discouraging. It's not impossible, but it's a tough battle.

DR. MURPHY: I think that risk management is becoming of age. I think that the PLI companies, the insurers, are putting us on really excellent courses. They tempt you to go. They give you a small discount from your premium. I have learned a lot and continue to learn by going to them.

At my hospital medical staff I have set up educational seminars on risk management. I have invited the Joint Commission to talk to us and discuss things, shared visions and so forth. There are many avenues to pursue within various risk management situations.

MS. MULLIGAN: Rosemary Mulligan. I would be interested in knowing from Ms. Schwartz how many Medicaid clients your law firm has ever represented. As far as risk management goes, how does the state work with Medicaid providers in order to do that [contain risk]?

MS. SCHWARTZ: Well, I guess my question is the easier one. Certainly anyone that is over the age of sixty-five, we have to look for. There are many Medicaid recipients much younger than that. They may have a lien. Before I pay myself, I have to determine what that amount is. I want you to know that we don't have any better ease of dealing with Medicare.

It can take us sometimes two years to find out about their lien and another several months, at a minimum of ninety days, for them to address the problem of "now we have a check that somebody is ready to pay us, how much do we owe you?" So, there are certainly governmental questions. I wish a federal representative [could] come up with a better means of adjudicating that problem [of liens]. It holds up payment and it holds up settlements in a lot of cases because insurers are reluctant to settle without knowing the extent of the lien, but Medicare isn't the only problem.

PROF. CROSSLEY: Are you aware of what volume of your client load might be Medicaid patients, not Medicare, but Medicaid?

MS. YOUNGBERG: This is very unscientific evidence, but my organization works with a number of safety net institutions and private or large teaching facilities. I think that the Medicaid population as a whole tends to be less inclined to sue than people that are better educated. We even find when we do a claims analysis annually, low-income and elderly patients seem to be less likely to sue than any other group. I don't think we have as much volume [among Medicaid patients], at least anecdotally, in the claims that I have seen.

MS. SCHWARTZ: If I could add to that for a minute. Again, I told you that medical malpractice cases are less than ten percent of the cases that are in my office. I can comment affirmatively that in terms of those people that are calling in and being evaluated, the elderly are scrutinized more severely than the younger in terms of whether we are going to take this case because

of the business decision that is being made, is it worth the time, effort and money that we are going to have to put into this case to prove it.

MR. ZAREMSKI: I am Miles Zaremski with Kamensky & Rubinstein. What is the crisis and what is the solution? The crisis, whether it was the 1970s or the 1980s, seems like it is driven by malpractice rates that are spiked. Physicians can't practice, their revenues are capped and their expenses go up, and they are leaving Illinois, leaving other states, retiring, et cetera.

So to me that's the problem, or the crisis. What's the solution? Now, I believe that what we have come up with in the past, or what our legislators have come up with in the past—tort reform—just doesn't work. We have to think out of the box.

One of the things Russ Pelton touched on in his presentation strikes a chord, because in 1998, the AMA, I believe, passed a resolution that said that testimony should be considered the practice of medicine, giving a deposition or expressing it in an affidavit.<sup>23</sup> In order for Susan to go into court in the State of Illinois, for example, she needs a Certificate of Meritoriousness and to proceed to a settlement or judgment, she needs a medical expert.

So my question is, with that as a foundation, Russ, what do you think about having the practice of medicine be inclusive of testifying?

MR. PELTON: I think it definitely should. The AMA resolution to that effect was that the AMA regards providing expert testimony as the practice of medicine.<sup>24</sup> One of the elements in Judge Posner's decision is he said that Dr. Austin was in fact providing medical care to the patient when he provided expert medical testimony on her behalf.<sup>25</sup> I think the question of whether expert testimony is the practice of medicine is something that should be looked at more carefully.

There was a recent study of the medical licensing board in all fifty states, and they showed that about fifty percent or more of the members of the licensing boards were unsure whether providing testimony was a practice of medicine.<sup>26</sup> In seventy-one percent of the states they had never disciplined any physician for giving improper testimony or unethical testimony in

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23. See AMA Board Report regarding Expert Witness Testimony, Report 18-1-98 at 104-110 (Dec. 1998).

24. *Id.*

25. *Austin v. Am. Ass'n of Neurological Surgeons*, 253 F.3d 967, 974 (7th Cir. 2001).

26. Douglas R. Eitel et al., *Medicine on Trial: Physicians' Attitudes About Expert Medical Witnesses*, 18 J. LEGAL MED. 345 (1992).

court.<sup>27</sup>

I think that is part of the problem. I think that if you had a clearer definition or acceptance of the fact that providing testimony, diagnosing a patient, and analyzing his or her treatment is part of the practice of medicine, then the problems that I talked about can be dealt with at the licensure level more effectively.

DR. ALEXANDER: Jay Alexander, I am a cardiologist. I just want to make a few statements. Number one: access can't be defined by one percent of healthcare dollars involved in this, but rather ten to twenty percent of my revenue going toward paying for malpractice insurance. When it goes up thirty or forty percent, I can't stay in practice. That's how access issues occur.

When doctors decide they need to go into boutique medicine because they can't make ends meet and they certainly have a problem with collecting a reimbursement that's flat and soaring malpractice rates, they take 500 patients out of the 4500 that they had and 4000 patients are without doctors. That's an access problem.

When doctors no longer want to do procedures that put patients at potential risk because they don't want to be at litigious risk, that's an access problem. That's the access problem that occurs in Illinois.

Now, a couple of other things that I think are relatively important is that a number of the cases, Ms. Schwartz, that you brought up were actually strictly economic damage issues. The last case I agree with you, it was truly a non-economic issue. The bottom line in the State of Illinois is that we are not going to get a cap on non-economic damages. We need to look at other issues. Here is a physician that says look at other issues.

One of the issues that you brought up is that we need to get rid of the whore expert witnesses. We need to get rid of the Austins. We need to get rid of those people who give testimony from California, or Utah, or from other places only and no longer see patients. If the standard of care is what we practice, it should be a practicing physician in the specialty of those doctors.

I applaud the neurosurgeons, not for asking their members not to testify, but rather for setting standards for which they should be able to testify and to review those. I hope that my group, the American College of Cardiology, does the same thing. I think that is an enormously important thing for us to do.

We need to, as physicians, find the cases that in fact are truly malpractice—where people are injured—and we need to reward them. We

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27. *Id.*

need to reward them in a timely fashion. We need to reward them in a reasonably fair fashion, not \$30 million where half of that money goes elsewhere.

I would hope that one of the take home messages from this is not pointing fingers at an insurance industry, or physicians, or even the trial lawyers. I think the bottom line is we need a system because soon we will not have physicians in Illinois. One more thirty-five to forty percent increase in premiums and you will see your crisis that you are wondering whether it truly exists or not.

MR. PELTON: If I could respond to one of your points, Doctor. The AANS has never said to their membership they should not testify for plaintiffs. In fact, part of the written policy in their guidelines is that all neurosurgeons are encouraged to testify on both sides, when appropriate, but when doing so should follow these standards.

During the *Austin* case, Dr. Austin raised the issue that this was a program aimed only at punishing physicians that testified for plaintiffs. The depositions of all the members of the Professional Conduct Committee were taken. These are the fellows who make the recommendations to the Board. All of them have testified as plaintiff's experts in the past, when appropriate. So it's not an organizational policy against plaintiff's experts. It's an organizational policy against bad testimony.

DR. ALEXANDER: I am sorry to see the one letter sent by the President of the American Association of Neurosurgeons being taken as a bad thing, when I'm sure trial lawyers do in fact put out letters asking for support of those who are against caps or against tort reform. I would venture to believe there has got to be a coincidence that two-thirds of the money that Dick Durbin ran off of last year came from trial lawyers.

MS. SCHWARTZ: I would like to respond to that. First of all, trial lawyers are criticized for contributing money, but I am going to ask you who else is going to speak for our client base? We don't have the AMA. We don't have each and every one of your professional societies from pharmacists to the pharmaceutical companies to all of your lobbies that you have. The patients who are going to be the next victim don't know it's going to be them. It could be you, Dr. Alexander, and you have to have heart surgery by one of your colleagues one day, brought on, I'm sure, by the stress of my profession.

But in all fairness, I was trying to use the letter to the neurological society for a specific purpose. I believe that the public has been misinformed and has been told that the only reason that malpractice

premiums are going up is because we do not have caps. That is clearly the message that Karl Rove, George Bush, and organized money in America is trying to present to the public.

I suggest to you that if your fellow physicians had the benefit of all the studies that were here and all of the information that's in the two recent GAO studies,<sup>28</sup> they would understand that caps will not reduce insurance premiums.

DR. ALEXANDER: If you heard me, I said that I don't think caps are the answer.

MS. SCHWARTZ: And I do understand.

DR. ALEXANDER: I think that physicians believe that there is more to this than just caps.

PROF. CROSSLEY: One last short question.

DR. AMATO: It's not a question, but a comment. I'm Joe Amato. Mr. Pelton, I think you know that the Society of Thoracic Surgeons this February will adopt a resolution that I have been working on for ten years creating a list of physicians that will testify for plaintiffs. I believe that that's extremely important to our society.

I will also say that I think being a physician, and now being a M.J. [Masters of Jurisprudence] student at Loyola, that I think that the most critical things that were said today were, number one, communication, and perhaps number two, the education of the physician on some legal matters. I think education is very, very important. A lot of doctors don't know a thing about informed consent, Good Samaritan laws, et cetera. I can continue on, but I won't. Lunch is waiting. Thank you.

PROF. CROSSLEY: Thank you. And thank you to our panelists.  
(Whereupon the colloquium was concluded.)

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28. GAO, *supra* note 13, at 25. See generally GAO, PUB. NO. GAO-03-702, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES (June 2003), available at <http://www.gao.gov>.

APPENDIX C: PROFESSIONAL LIABILITY (PLI) SURVEY

Professional Liability Insurance (PLI) Survey

Dear Colleague:

Next week I will make a presentation on physician perspectives of PLI at the Loyola University School of Law/Institute of Health Law Colloquium. I wish to include a survey of your perspectives in my discussion. Would you please complete my survey.

I. I think the cost for PLI coverage is fair: Yes \_\_\_\_\_ or No \_\_\_\_\_
Comment:(Print) \_\_\_\_\_

I think non economic damages should be capped at \$ \_\_\_\_\_

I am a PCP \_\_\_\_\_ ; Specialist \_\_\_\_\_
(Choose one please)

Comment:(Print) \_\_\_\_\_

II. Which Group/Entity is primarily responsible for escalation of physician PLI premiums? List at least 3, with #1 as the most responsible:

- Government
Hospitals
Insurers for PLI
Lawyers
Managed Care Plans
Physicians
Politicians
Public
Other

Comment: (Print) \_\_\_\_\_

III. If PLI premiums are higher in 2004, I will (check all that apply); Circle one item that is most likely to happen of numbers checked.

- make no changes in my practice
quit practice
retire earlier than planned
move to a PLI more friendly location
quit practicing in hospital
go bare (no PLI)
become an employed physician
change careers
join a group
reduce patient access
educate my patients on lawsuit prevention
study issues more (CME)
lobby with organized medicine for tort reform
reduce practice hours
try joining a union if possible
modify my life style
decrease number employees
decrease remuneration to employees
decrease technology and amenities in my practice
consider countersuits
decrease volunteerism (medical staff & hospital committees, teaching, community service)
decrease professional memberships
stress QA/QI in my practice

Comments:

Joseph L. Murphy, M.D.
President, Medical Staff