Will Your Lawyer Deliver Your Next Baby - The Effect of Raising Malpractice Insurance Costs on OB/GYNs

Sara Imershein

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Dr. Sara Imershein:

I am going to talk to you about how rising malpractice insurance costs affect physicians. If you are a parent you know that childbirth is a pretty scary situation for a family. One of the common complaints that we hear is that doctors perform too many Caesarian sections. The fetal heart rate monitor, which was designed in the 1970s by Dr. Hahn, is a way of monitoring heart rate changes of the unborn fetus. This was established as standard of care in the 1980s, not by any double blind, controlled, or crossover clinical study, but by legal precedents. No controlled medical studies have ever proven that women who have had fetal monitoring have healthier babies than women who do not have fetal monitoring. However, to forgo fetal monitoring would be considered malpractice or negligence today. Anytime you look at a normal population of 100 people, five percent will fall outside the normal range.

Now let us take a group of women in labor. Discovering a fetal heart rate abnormality might show us an existing problem or a potential problem. We are talking about serious long term problems with long term effects. So let us say there is a five percent risk that a baby will be damaged if we do not intervene. If it is my baby, I want a Caesarian section because five percent is an awfully high number when you know that the baby can be delivered safely right away. That said, if only five percent of the babies have an actual abnormality, many unnecessary Caesarian sections are being performed. We know that three to five percent of all children born are going to be abnormal, regardless of what doctors do. It is like planting your garden: not every flower will bloom. We are going to be doing a lot of unnecessary Caesarians because mothers and fathers are not willing to take the risk.

The second thing I want to talk about in terms of why doctors feel squeezed in all directions is affordability, which is why you are going to see fewer and fewer doctors like myself delivering babies. OBGYNs’ overhead has gone up substantially in the last ten or twenty years. Generally speaking most of us run a business with overhead of about fifty to fifty-five percent. A fulltime OBGYN in Washington, DC pays about $135,000 a year in medical malpractice premiums. That covers up to one million dollars per malpractice event and up to three events per year. That is the same coverage that most of us had twenty years ago, but it does not cover a lot of the current lawsuit settlements or judgments.

As you all know, a lot of lawyers won’t take a case unless it is a seven-figure case because it is very expensive to take a case to court. You have to put that expense up front if you are working on a contingency basis. You better be sure that it is worth a lot of your time to invest that money. We are paying $135,000 in premiums a year, but are getting reimbursed less and less every year. The average OBGYN makes about $200,000 a year, works about 60 to 80 hours a week, and then goes home at night worrying about what he or she did wrong.

If you deliver an average of 110 babies a year with an average payment of $2000 and your insurance is $135,000, do the math. You have $85,000 left after you pay your malpractice premiums. You then have to pay your office nurse, your receptionist, and your rent.

We also have many non-reimbursable expenses. Every time you make a phone call to your doctor’s office, somebody has to look up your chart, pull out

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that record, and give it to the doctor for approval. Most law firms bill you for that; doctors get nothing. These are overhead expenses. If Joe calls to find out how his elderly mother is doing and spends several minutes explaining what is going on, the conversation is non-reimbursable. We are squeezed at both ends. Our overhead costs have gone up by forty percent in the last ten to twenty years. Our reimbursements have gone down by about forty percent as well. I received those numbers from the American Medical Association (AMA) yesterday. The average doctor is making less than fifty percent of what they used to and the average medical school student is graduating at thirty. If you go straight through in law school you are about twenty-five when you graduate. The average doctor puts seven or eight years into their training after college and graduates with a $250,000 debt. You cannot lower tuition by adding another student in medical school. You can always bring another chair into a law school and lower tuition a little bit by getting one more student to pay. The rate limiting step in medical school is usually the gross anatomy lab. It was thirty years after I graduated from Emory University Medical School before they enlarged their freshman class. They had to build a whole new building to accommodate the gross anatomy lab to enlarge their freshman class of medical students.

Between our increasing expenses and our decreasing reimbursement, a sense of depression has fallen over much of the medical community. There is also sense of hopelessness because many of us are making maybe twenty to fifty percent more than the nursing staff at our hospitals who are working very nice forty hour work weeks with time and a half for overtime. I don’t want to whine. I love what I do. I love taking care of women.

Corrine Parver*

I became interested in this topic when I was out for dinner one evening with a group of friends, some of whom were physicians. Somebody said that the University of Maryland had not sent a single one of their medical students into an OBGYN residency. This trend apparently has been repeated in many medical schools across the country. I was concerned on the one hand because I had a daughter who wanted to be a mother and a daughter-in-law who wanted to be a mother and I wondered who would be their doctors.

At the same time I looked at it from the standpoint of the disproportionate effect that a shortage of OBGYNs might have on women of color. Everything that happens to Caucasian women, at least in this country, has a multiple effect on the negative side for women of color.

I began to do some research in this area a couple of years ago and found to my dismay that, from a legal standpoint, there was no literature on this particular topic. I thought, what is causing doctors not to go into OBGYN? I remember when my husband was a medical student and going through the different specialty trainings. He came home after his first day with an OBGYN, said “That is the kind of doctor I want to be. It is such a wonderful, happy, profession, and the women are happy and the babies are healthy”, but he did not end up not going into that specialty. It left a big impression on me. Why are people not feeling the same way about the OBGYN specialty? Why do young doctors not want to be OBGYNs? Why do many practicing OBGYNs get out of obstetrics and end up just practicing the gynecological surgery and medical aspects of the specialty? Could one of the reasons be that lawsuits and high malpractice insurance costs are deterring and scaring people away from practicing OBGYN?

In our research on the effect of the medical malpractice insurance crisis on women of color, we took a look

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at five states across the country to get some data to begin the discussion of whether people are not going into this specialty because of increasing medical malpractice insurance rates. Our research was published in the 2007 *Journal of Health & Biomedical Law*, Suffolk University Law School. We were not able to come up with a specific conclusion as to whether that was the sole reason people are not choosing this specialty. We do know, as we heard from Dr. Imershein, about the rising cost of medical malpractice insurance, most specifically for obstetrics.

We wanted to see whether there is a barrier to access to care for women of color because of medical malpractice issues. The fact that minority women have a propensity to choose physicians of their own race and ethnicity has been demonstrated in several studies. Medically indigent women are four times more likely to receive care from non-white physicians than non-Hispanic white physicians. If you have a woman who wants to receive her care from a physician who is from the same race and ethnicity— you can see that her access to care could be completely blocked. There is also a perception, although it has been unsubstantiated, that poor women are more litigious than women of means. If you have statistics that show that African American women bear the brunt of the poverty in the United States, that would increase the fear of even minority physicians going into this particular specialty.

Another factor that we looked at was that medical malpractice insurance coverage in some states is forcing physicians to abandon the practice of medicine entirely. Years ago your family physicians, and other physicians, would work until they died in the office, or at least until they were eighty or eighty-five years of age. You just do not see that today. You see young physicians leaving the practice of medicine, as well as going out of the specialty of obstetrics. We looked at five states and tried to determine what the numbers were for physicians and to derive a correlation between numbers of physicians treating patients and access to care. We looked at California, Nevada, Arizona, Mississippi and Maryland. Some of these states have been labeled medical malpractice insurance ‘crisis states’ by the American Medical Association (AMA). The remaining states are showing some problem signs.

California is a heavily regulated state when it comes to medical malpractice. The Medical Injury Compensation Reform Act (MICRA) was passed in the mid-1970s and has been held up as the gold standard for other states. In looking at the female population, you can see that there are more women of color than Caucasian women in California. Eighty-one percent of women in California have health insurance, a national rank of thirty-fourth. Why is that number so low? It is so low because the proportion of women of color in that state is so high. Then we took a look at the number of physicians in each of these states. These statistics have just been updated; they are 2007 numbers. Of the 4,300 California OB-GYNs, only 113 are African American. The ratio of black OB-GYNs to black women is one to almost 11,000.

Maryland is also pretty heavily regulated. There has been a huge increase in medical malpractice insurance rates in that state. The non-Caucasian population is slightly smaller than that of California so we would expect to see better numbers. Indeed Maryland ranks fifteenth in the country for women with health insurance. One interesting statistic that we looked at was the high percentage of African-American, Hispanic, and Asian women in Maryland who receive routine check-ups. There are less than 1000 OB-GYNs and of those only twenty-seven are African American. There is a ratio of one African American OB-GYN per 30,000 African American women. This is a huge disparity. If you look back to the studies that showed that women prefer to be treated by physicians of their own race and ethnicity, you begin to see how difficult it is to achieve high access to care for women of color.

We looked at the effect of tort reform in 2000 on access to care in Mississippi. Mississippi ranks forty-third in terms of percentage of women who have health insurance. There were only six African American OB-GYNs in 2006 in the entire state of Mississippi, a ratio of almost one in 90,000.

Arizona currently ranks forty-first for the percentage of women who have health insurance. Far fewer African American women receive routine checkups than in the other states that we looked at. Here the ratio is a little bit more positive. Fourteen out of the state’s 221 OB-GYNs are African American, for a ratio of around one per 5,000.

Nevada has similar non-Caucasian and Caucasian populations. It ranks forty-seventh for the number of women who receive preventive care, which is one of the lowest percentages of women who have health insurance. There were five black OB-GYN’s out of 231 in 2006, for a ratio of one in almost 15,000.

So as I said when I began, this was just a preliminary examination of the issue of access to care for women of color. Much more work has to be done in the area, but I found it personally very discouraging for all of us. I wonder how we can possibly encourage more women to enter this field. I would guess that the percentage of female OB-GYNs today far exceeds that of twenty or thirty years ago, but it is a specialty that should be encouraged by medical schools. It is disappointing when you read about medical schools doing the exact opposite. We are continuing to look at this area and trying to determine whether greater tort reforms should be enacted.

Steve Pavner*:

I think that both Professor Parver and Dr. Imershein have laid out the problem. It is a problem that clearly exists. It is often referred to as the ‘medical malpractice insurance crisis’, and from my perspective, the emphasis should be on the word ‘insurance.’ In short, there are those with an interest in a certain outcome, who refer to it as the ‘medical malpractice crisis.’ I am going to show you some data to suggest that the emphasis should not be on the medical malpractice system or on the jury system, but that the emphasis should be on the insurance system.

Clearly doctors are facing a big problem and I think Dr. Imershein laid it out pretty clearly. The problem is multi-faceted. It involves skyrocketing consumer costs, health costs, and health insurance premium costs. Yet, despite the fact that as consumers we are paying a lot more for our health insurance, the persons delivering that healthcare to us are receiving less and being squeezed.
In some cases, as Professor Parver implied and Dr. Imershein suggested, OB/GYNs are leaving the field. This raises some issues with respect to the profession and leads to the provocative title of this first panel of this symposium “Will Your Lawyer Deliver Your Next Baby?” There are essentially four popular ways to explain this crisis. First, that there are frivolous lawsuits. Second, that we live in a litigious society and so not only are there frivolous lawsuits, but there are a lot more lawsuits. Third, that there are more plaintiffs’ verdicts. This is the idea that often times a jury will return a plaintiffs’ verdict out of sympathy, not because the evidence indicates that there should be a plaintiffs’ verdict. Fourth, that when there is a verdict for a plaintiff, it tends to be for a high payout. This is something that Dr. Imershein certainly alluded to – this notion that if the OB/GYN has limits, insurance limits of one million to three million dollars – that that might not be adequate in the case of what we lawyers refer to as a ‘bad baby.’ By ‘bad baby’ we mean a baby who has suffered some birth problem, oftentimes anoxia or hypoxia during the birth process. If it is not anoxia or hypoxia it could be something called shoulder dystocia that leaves a baby with a limp arm. The questions for us should be why does the malpractice insurance problem exist and what is the relative merit of these popular explanations.

One popular explanation was in a cartoon I saw. The cartoon reads, “[i]f you close your eyes and make an allegation someday it might come true.” I thought this captured the notion that frivolous lawsuits are being filed. Specifically we are talking about lawsuits in the context of the delivery of babies, basically obstetrical problems. Of course we as lawyers know when we handle these sorts of cases that the last thing in the world we want to do is take a case that does not have substantial merit. We know that there are rules to sanction us if we bring a case that does not have substantial merit. We know that as a practical matter if we file a frivolous case, because these cases are brought on a contingent fee basis and because there are substantial costs associated with bringing these cases, it is not in our economic interest to bring a case that does not have substantial merit. Additional hurdles that we have to meet before we can bring a case include pre-screening requirements. For example, in Maryland there is a requirement that we initially file a lawsuit before something called the Health Claims Alternative Dispute Resolution Office. As part of that, within a certain period of time, we are required to file something called a certificate of a qualifying expert, or qualified expert. This is essentially an affidavit by another physician in the field who says under oath, that “I have reviewed the facts of this case and in my opinion with reasonable medical probability Dr. Smith violated the standard of care and caused damage to the plaintiff.” My point is that there are procedures in place, both in terms of our own self-interest and in terms of procedures imposed upon us by the system, which are intended to, and I would suggest in many cases do successfully, weed out and diminish this notion of frivolous lawsuits. We do not want to bring frivolous lawsuits and there are systems in place to discourage us from bringing frivolous lawsuits.

The second popular explanation is that we live in a very litigious society. It is true that we have a system of justice – and I would be willing to defend that system of justice that is designed to result in the peaceful resolution of disputes. If one party feels aggrieved by the actions of another, there is a peaceful process that exists to resolve the dispute. The process is designed to try to bring resolution to that dispute and to try to make people who feel aggrieved believe that they have some redress. This is an important process that is necessary to the very fabric of our system of justice. That system does require physicians, when we are talking about personal injury cases or medical malpractice cases, to become involved. From my own experience, in some sense many physicians enjoy being involved in that process for a number of reasons. One is the intellectual challenge and the other is that it tends to be remunerative and it helps compensate for the other

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problems that some physicians are facing with respect to being squeezed. The notion that we live in a litigious society holds some truth in the sense that we know that we have access to the courts. However there are no studies that suggest that there has been some explosion of litigation or that there has been any disproportionate increase in the number of lawsuits. Given that we have an increasing population, it stands to reason we would have an increasing absolute number of lawsuits, but there is nothing disproportionate about it. I am not aware of any studies that suggest there is any particular disproportionate explosion of litigation in the medical malpractice area.

If those two popular explanations do not explain the problem, then how about this notion that there are more plaintiffs’ verdicts in medical malpractice cases? A pie chart presented at another conference that we had on a similar topic here at American University in 2005, by a gentleman by the name of Larry Smarr, the president of a major malpractice insurance company, Physicians Insurance Association of America (PIAA), attempted to explain the resolution of lawsuits that are brought in the United States. This was data from PIAA, so it relates to PIAA insurance. What Mr. Smarr indicated was that basically sixty-one percent of medical malpractice lawsuits are dismissed or dropped. There are some minimal administrative expenses that the insurance company incurs in reaching that resolution, but the cases are dropped or dismissed before they go through the full litigation process. In addition, a number of cases settle. Any insurance adjuster will tell you that they settle the cases they think they are going to lose. They do not settle the cases they think they are going to win. When they try those cases, as you would expect, there are many more verdicts for the defense than there are for the plaintiff. Why is that? Well as I indicated, they try the cases they think they are going to win and they settle the cases they think they are going to lose. You would expect that result. Of all the PIAA malpractice cases that are filed there are about thirty-three percent that represent plaintiff’s verdicts. The overwhelming majority are dropped or dismissed and only about seven percent of them go to trial, where the substantial expenses are incurred.

The New York Times published an article not too long ago in which it looked at this particular phenomenon. They authors looked at the phenomenon of the increase in malpractice insurance premiums and the alleged relationship of that increase to increasing malpractice payouts. Their conclusion was that the payments for malpractice claims, although increasing, were not increasing at nearly the same rate as the increase in premiums. The question then becomes, what is the cause of the explosion in malpractice insurance premiums? I think the answer was presented right here by Larry Smarr of the PIAA at the conference I mentioned previously. He presented it in short form under the title PIAA Data Sharing Project, Claim Payment Trends. He presented the loss and loss-administration expenses from 1995 to 2003. Loss-administration expenses are basically paying the adjustors, paying the lawyers to defend the lawsuits, and paying the costs associated with getting experts involved in the lawsuits. They increased from ninety-seven percent in 1995 to 105 percent in 2003.

What does that mean? The insurance company takes in an insurance premium from the doctor and holds that premium. It does not pay a claim the day it takes in a premium. It may never pay a claim or it may pay a claim five or six years later. This is what the insurance business is all about.

It is based upon taking in premiums and then hopefully not having claims, or paying out claims long after it has earned money on the premiums. So insurers take in the premiums, invest that money, and then pay out claims. They are prepared to pay out even more than a dollar for every dollar of claims. Why? Because those are absolute numbers; a dollar taken in and a dollar paid out. They separately account for the interest they can earn on holding that premium dollar until they pay it out. You can see that as the insurance company starts to pay out a little more money, they reimburse fewer dollars to the policyholders. That is one of the cushions they have. Then they have a column called “adjusted combined” in which they account for the combined expenses plus the policyholder dividends. “Adjusted combined,” as you see, is merely the sum of “Combined”—which includes losses, loss administration expenses (LAE), and underwriting expenses—and “Underwriting Policy Holder Dividends”—which is to say, what they are reimbursing to the doctors to reduce the cost of the physicians’ cost of malpractice insurance. And what you see when you read across the chart is that, from 1995 to 2003, there is absolutely no change. I mean it is not perfectly flat. You wouldn’t expect it to be perfectly flat, but the ratio of dollars paid out to net dollars earned from premiums happens to be exactly the same in 1995 as it was in 2003.

But what changes dramatically is their net investment income, what they make in the market. Doctors and lawyers have no impact on a company’s investment decisions. This is simply what the insurance companies decide to do with those premium dollars. The net investment income decreased by more than fifty percent over the period. It went from forty-six percent on the dollar all the way down to twenty-one percent. Then after accounting for income tax PIAA’s net income took a nosedive from twenty-three cents on the dollar to a loss of two cents on the dollar. So in other words they lost money. But the question is why, and the answer I suggest is right in the data that Mr. Smarr presented. Step number one in fixing a problem is identifying the true cause, not establishing some bogeyman.