LOOKING OUTSIDE THE BOX

BY
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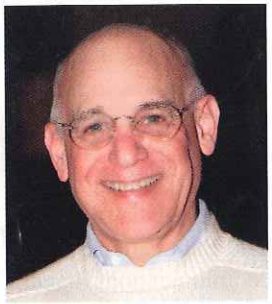

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Frankly, I'm a bit fatigued trying to assess how we got here, and I really don't care very much. Whether any of the following popular attributions make sense is subjective and a product of the bias of the analyst:

- The CAT Fund never pays.
- Too much bad medicine.
- Too much greed everywhere.
- Liability insurers need to pass on premium increases because of declining investment returns and 9/11 losses.
- Various fraudulent and/or inept underwriting and claims practices by professional liability carriers, some now bankrupt or insolvent.
- Trial lawyers are too powerful.
- Jurors are morons.

The fact is, claims and suits against doctors and hospitals keep proliferating. They are expensive to manage and even more expensive to win. Counsel fees, expert witness charges and claims-overhead allocation eat up premium quickly. Insurers are safer betting on a resurgence of WorldCom shares than on the claims record of even the best obstetricians. (Actually, the best get sued more often because of the medical envelopes they push.) Frequency of claim rather than medical merit is now the most important aspect of insurability and premium calculation.

If there is any possibility that understanding why we're in this place will deposit the breadcrumbs to a solution, I suggest looking outside the box. To quote Pogo, "We have met the enemy and he is us."

ARE YOU A BETTER MAN THAN I AM, CHARLIE BROWN?

The last decade or two of life in these United States will never be confused with the golden age of personal responsibility.

In terms of both work ethic and basic morality, the days when the world did not owe us a living seem to have vanished in the haze of the 21st century. No matter what unfortunate event befalls us, no matter its cause or origin, there is a growing consensus that somebody, or everybody, must pay. The public, not the courts or the Legislature, has seemingly redefined the practice of medicine as a strict liability sport, a concept no doubt made easier by the no-fault concepts patients deal with all the time — divorce, workers' compensation, products liability and auto accidents. We have become an extremely litigious society on all fronts. The medical malpractice debate is but a small piece of that blatant truth.

Sure, personal responsibility works both ways. Why shouldn't a physician be held responsible for injury caused by a mistake? Organized medicine does not argue otherwise, nor does it deny that plenty of mistakes injure plenty of people. (Doesn't our new "saving" legislation refer to itself, in part, as a "Reduction of Error Act"?) We do not often hear that findings of error against health care providers are too numerous. Instead, what has been argued is that the system of compensation has run amok and that awards are out of proportion to victim need. Doctors seem oblivious to the notion that these "outrageous" jury awards are being returned by their patients.

Jon C. Krause

Amid proposals to cap malpractice awards for pain and suffering and limit the manner by which future damage payments are calculated and paid, I have posed the following hypothetical scenario to numerous groups of doctors, all of whom seem shocked at the reference to the concept of equality. If a neurosurgeon makes a clear mistake, resulting in the death of a 42-year-old CPA earning $150,000 per year, married with three children, all agree we have a big case. If I drive through a stop sign and kill the same man, all agree the case is just as big. But no one has yet come up with the answer to my question: Who do I see to limit my liability?

Pennsylvania's frequent adoption of hot legislation has a spotty history of solving the sexy political issues of the day. Legislating support for one problem frequently creates disaster elsewhere. Auto and medical malpractice legislation have taken turns limiting or abolishing the collateral-source rule in tort cases. Whether automobile or physician premiums will benefit is questionable, but look at your health insurance bills. Shifting the dollars helps the legislators avoid both the heat and the real problem at the same time. Interest groups, PACs and those they seek to influence avoid rather than address the big picture: Health care providers, their patients and the reimbursement carriers don't seem to like each other very much.

The Rock and the Hard Place

Medicine as a business is tough in Pennsylvania. Except for specialized elective procedures, nobody actually pays the doctor's bill. Even the smallest practice requires layers of clerical employees just to keep up with the forms, phone calls, reviews, referrals, pre-certs and complaints, all occasioned by the individual demands and quirks of health insurers. No compliance means no payment. Because the HMOs, PPOs, TPAs, etc. control payment to doctors and hospitals via a vast network of (dis)agreements, there is absolutely no opportunity for health care providers to do what every other business does under similar circumstances — pass on the increase to the customer. Where the revenue side of the equation is controlled and the cost side is spiraling upward, there is often little chance for economic survival.

Recently, a local orthopedic surgeon told me of a patient whose sister needed a knee replacement. Living alone in Maine, the sister decided to have the surgery done in Pennsylvania so that family could assist with convalescence. When the bill hit Blue Cross of Maine, reimbursement to the surgeon was double what would have been paid in Philadelphia.

While admittedly escalating medical costs would not reduce the onslaught of claims against doctors, as most patients themselves pay neither the actual bills nor the insurance premiums, the inability to pass along normal and abnormal costs of operation encourages doctors to practice elsewhere.

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Great Expectations

Patients assume they have a right to expect that no procedure or treatment will ever go wrong. Advances in technology and medical knowledge have convinced us all that there is no reason for medical care not to produce desired results. High-risk specialties are not so named without reason. Neurosurgery, obstetrics and gynecology, and orthopedics have become a patient's Powerball lottery.

For instance, babies today are conceived through technology not available when I graduated from law school in 1968. We expect a baby born under 1,000 grams and 25 weeks' gestation to survive without incident, despite the fact that Saturday night's dinner at a good restaurant weighs more. When unavoidable and catastrophic sequelae occur, the burden is too great and therefore the result must have been occasioned by negligence. With the ability to create miracles comes the responsibility attached to failing to create them.

It is true, I guess, that statistics don't answer all of the questions. The "one chance in 300" could be the negligence factor rather than an inevitable failure rate. Doctors have advanced us to where all of our expectations are heightened. We do not tolerate disappointment well.

OK, This Is Not a Bill, But What Is It?

Patients are totally fed up with the system that delivers and pays for their health care services. While probably not the primary targets of patient wrath, doctors have done little to dissociate themselves from those seen by patients as the real culprits: the health insurance companies. John Q. Public believes it is his birthright to expect cutting-edge care no matter the cost, no matter what the disease and certainly no matter what his age. Compromise in none of these areas is acceptable. Generally, doctors agree with John and do not react well to the restrictions of cost-contained or managed care. White coats look alike, though, and the public lumps together everyone within the system causing so much angst.

Why? We are no longer permitted relationships with doctors! We don't go to Marcus Welby, M.D., because of his charm or even because of Consuelo. It's because he signed onto the network, and if he didn't we either can't use him or must incur a co-pay and/or a deductible. Because he did sign on, he gets to treat us for inadequate fees.

Perhaps Dr. Welby got smart a few years ago and sold his practice to a "health care system" that boasted the ability to manage the practice better, pay high salaries and pick up all the expenses, including malpractice insurance. After a few years of forcing doctors to see too many patients per day and spend far too little time with any of them, the patients identify with no one and the system has lost enough to cause them to divest, i.e., give back, the practices.

Couple all of this with the specialization that modern medicine requires and it is easy to see why patients have no sense of identification with their care providers. They don't speak with reverence of "my nephrologist." Actually, it's Maryanne Saddleshoes, the generic clipboard and checklist minder at Liability HMO, who determines whether you suffer or have your gallbladder out or whether you get the medication actually prescribed or a cheaper close substitute that's "just as effective."

Then, too, it's so easy to clear up problems or get a question answered. "Explanation of Benefits" forms that create more havoc than they explain and automated phone menus that lead nowhere merely pile it on.

Doctors can argue standards of care all they want, and they're probably right most of the time. All the juror thinks about during deliberations, however, is that he can't get more than a month's worth of medicine because insurance demands a new co-pay every 30 days.

We're Not in Kansas Any More

I was intrigued by the views expressed recently during an administrative conference by a respected common pleas judge in Philadelphia. He referred to the current situation as a crisis of verdicts instead of a "malpractice crisis." His point was that the malpractice carriers, the doctors and the lawyers representing them are making decisions as to the risk of trial by standards that are out of touch with the mood of the community, i.e., jurors. It is obviously more difficult and more expensive to defend and win a high-damage case today than it was five or 10 years ago. The judge contends that carriers and the M-Care Fund haven't yet gotten this message and further suggests that insurance counsel must be more forceful in persuading their clients that the risk of a given case is higher than the doctor or carrier wants to hear. Whatever the reason, due diligence suggests that claims professionals and defense counsel evaluate more realistic criteria before allowing cases to go to a jury.

Over the years, I have represented hundreds of doctors and hospitals at the request of carriers. More recently, I have had the good fortune regularly to counsel doctors personally on issues where their personal interests and those of their liability insurers begin to diverge. Often, doctors are dissatisfied with counsel chosen for them and are never certain whether the low fees being paid (often causing legal children to handle most of the case) or the possible loss of the pipeline volume are more on the lawyer's mind than the best interest of the doctor. The doctor is the client and needs to be treated as such. As each layer of coverage tries to strong-arm the one below to resolve the case within its own limits, so as to avoid pushing the problem up the ladder, there are enough conflicts within the system to create chaos at times, even when handled ethically and properly.

More doctors should be counseled by personal lawyers where the case warrants it, and probably we are at a point where doctors should be given the right to choose their own defense counsel without regard to the "managed care" approach in place for so long. Getting what one pays for is not endemic to medicine.

Simply put, the medical profession needs to decide over what issue(s) this battle is to be fought. For now, the assault is economic. Reimbursement is too low. Malpractice premiums are too high. Jurors award too much money! Where do or should the economics of litigation fit in? Principle is expensive in the 21st century. After a few cases in which Dr. Kildare's carrier pays more to defend and win than the doctor's annual premium, principle matters less to the underwriter than to the doctor, at least until the availability of the policy disappears.

The marketplace is more artificially engineered every month. Malpractice premiums and service reimbursements can no longer seek their own levels, as politicians, corporate executives and interest groups determine not only how medicine is paid for, but also how it is dispensed. While the public might not be justified in generally condemning the quality of health care, it has every reason to be concerned about the quality of the health care delivery system. When the profession regains control of that process, it will again gain the respect of its patients. When that relationship begins to be repaired, the trickle down will eventually reach the jury box.

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