PINNACLE HEALTH GROUP
PINNACLE LOCUM TENENS
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PHYSICIAN NEWSLETTER
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FEATURE

The Tort Debate

Tort reform remains to be a prevalent issue in making healthcare more cost-effective. What are some of the main contentions for and against it? What are industry experts and physicians saying about it?

Tort reform directly affect malpractice laws as it caps the money patients can receive as an award from a physician or hospital they have sued for malpractice. They also limit punitive damages courts can order physicians or hospitals to pay, and although it differs from state to state, they also provide tighter limitations on suits that can be tried, dismissed or dropped.

In general, tort reform can also help dispense with frivolous suits in order for more legitimate ones to be taken up. This is emphasized by the fact that between 15,000 and 19,000 malpractice lawsuits are being received annually (the most current of which are from diagnosis, treatment and surgery) & that the American Medical Association (AMA) listed 22 states that are in a healthcare crisis in relation to medical malpractice. Moreover, according to Melissa Walton-Shirley, MD, of Medscape, over 80% of the world's malpractice claims are filed in the US.

For many industry experts and physicians, reimbursement systems and tort reforms remain to be the most

In this issue:

- **Building a Successful Hospital Medicine Program**
- **Pinnacle Health Group Surveys Docs about the Healthcare Reform Bill**
- **Success Story for a 241-bed Facility**

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Many physicians, industry professionals and other advocates continue to push to add legislative provisions that will decrease the overall cost of the country's healthcare system by restricting malpractice lawsuits, along with easing the burden on physicians.

Although tort laws vary from state to state, they commonly adopt caps on damages, joint-and-several liability, statutes of repose/limitation, attorney contingency-fee and periodic payment reforms as well as pretrial screening panels.

Since the 1970s, the US has confronted 'malpractice difficulties,' which, cites Frank Sloan, J. Alexander McMahon Professor of Health Policy and Management and Economics at Duke University, sprung from decreased insurance profitability, increased premiums and limited accessibility of insurance. Moreover, as early as the 80s, many states have enacted tort reforms to counter the rising insurance costs and declining insurance accessibility. Since 1986, 38 states amended their joint-and-several liability rules, while 23 states limited noneconomic damages (18 of which still implement it) and 34 states capped punitive damages.

THE CASE OF TEXAS AND OHIO

Increased malpractice insurance costs have been observed by industry experts as early as the mid-70s. Compared to overall healthcare costs, they have risen by 1,642% from 1975 up to 2000, which, of course, resulted in soaring insurance premiums. A study from the American College of Emergency Physicians (ACEP) reported that for the past years, emergency doctors have seen increases in malpractice premiums, while two out of three of EM physicians saw increases of up to 60%.

In the case of Texas, 31 out of every 100 doctors were sued. When physicians left their communities, its physician-to-patient ratio became 152:100,000, and were ranked as 48th for patients per physician (the US average during 2002 was 196:100,000). Health systems spent $400 million annually for their malpractice and legal costs while battling physician shortage—in fact, 158 of 254 counties did not have an obstetrician.

After the introduction of a tort reform in 2003, Texas' malpractice insurance costs decreased by an average of 21%—by 2007, about 600 OB/GYN physicians returned to practice in Texas. Resources acquired from malpractice savings enabled growth for some facilities. Christus Hospital at Corpus Christi launched its Diabetes Excellence Program; Driscoll Children's Hospital unveiled its satellite clinics in Brownsville and McAllen,

QUICK SURVEY

PHG Surveys Physician Perception on the Healthcare Reform Bill

Pinnacle Health Group conducted an email campaign by surveying physicians about their thoughts on the healthcare reform bill. The survey started in May and was continually sent to respondents until September 2010. We queried 5,000 actively practicing doctors, residents and fellows across the country, which yielded a 22% response rate.

Almost two-thirds of doctors who answered the survey worked for a for-profit facility, while 35% worked in non-profit healthcare groups. The demographic of physicians who answered the survey are predominantly single specialty and hospital-employed physicians (35.7% and 27.5%, respectively).

WHAT PRACTICE SETTING ARE YOU CURRENTLY IN?	
Solo practice	16.5%
Single-specialty	35.7%
Multispecialty	15.2%
Employed by hospital	27.5%
Locum tenens	5.1%

Physicians cite "compensation" as the most relevant issue that will affect physicians (91.6%) as well as the "financial implications of the reform on their practice" such as reimbursements and overhead expenses (81.9%). One physician remarked, "With the exception of the last two years, inflation usually occurs at a rate of 3% each year, yet Medicare reimbursements keep shrinking over the last 10 years. How is this system sustainable? If the workers' salaries and administrative costs keep increasing, doctors will soon go out of business or have an unacceptable standard of living, given all the responsibility and stress of being a physician, and leave the profession, especially since the government is trying to lower the Medicare age even further."

Another related, "The bill and other aspects of medical reform are only increasing practice overhead such as making EMRs essentially mandatory. They are also increasing the administrative work that is not compensated such as mandatory reporting of outcomes."

The quality of care delivered to patients is also a big concern for 77% of surveyed physicians. "I think the reform will leave us with an overall preventive care and care for minor ailments available to all, but anything beyond that will become 'rationed,'" opined one doctor. "Currently, the US has a significant number of chronic care and advanced care needs patients. The new healthcare bill does not provide adequately for the monetary or physician resources necessary to meet the needs of those patients. In addition, the profession of medicine is likely to become one of 'technicians' who learn the mechanics of providing

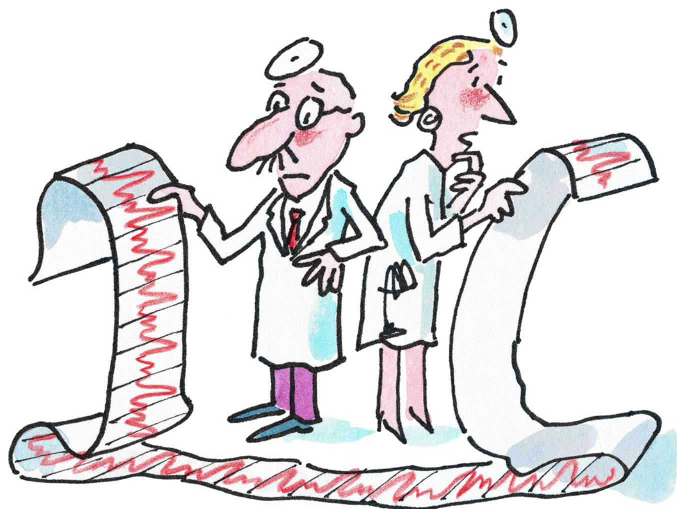
while the Houston-based Kelsey-Seybold Clinic set up an electronic medical record system.

Ohio's tort reform wasn't particularly the same. Although it decreased malpractice claims by 39% in 2008 by limiting noneconomic damages to $250,000 (except for outstanding cases) and making it more difficult to put cases to trial, employer-based family health premiums increased by 19% and averaged to $11,425 in 2008, up from $9,590 four years ago. Healthcare policy pundits say it may not be possible to determine whether overall cost would have increased further had the state not passed such a tort reform, given that its neighbor state, Kentucky, has not put further limitations in malpractice rulings but had healthcare savings.

On the other hand, the Ohio State Medical Association (OSMA) is optimistic, said OSMA spokesman Jason Koma. Although healthcare costs have increased, it has tremendously helped in regulating unnecessary tests and procedures. Koma remarked, "No one can argue that tort reform in Ohio hasn't brought down the practice of defensive medicine."

BOTH SIDES OF THE FIRE

"States that set limits on suing may only be able to go so far," remarked William Hayes, President of the Health Policy Institute of Ohio. He cited the Medicare spending as to why it is challenging to determine healthcare savings from tort reforms—in 2006, enrollees in Cleveland were to pay $8,377, $8,153 in Akron, $7,930 in Dayton and $9,612 in Elyria. The New York Times also pointed that there was an unusual, high percentage of angioplasty procedures performed by cardiologists. Moreover, Hayes also cited that despite Texas' leverage with its tort reform, it still remains to be one of the biggest Medicare spenders.



Tom Baker, University of Pennsylvania Professor of Law and Health Sciences, remarked at an earlier New York Times article, "As the cost of health care goes up, the medical liability component of it has stayed fairly constant. That means it's part of the medical price inflation system, but it's not driving it. The number of claims is small relative to actual cases of medical malpractice."

On the other hand, the Congressional Budget Office pointed out that a federal-level tort reform can reduce healthcare costs by $11 billion annually, and since the government pays majority of it, a nationwide reform could decrease the deficit by $54 billion in over a decade. Moreover, according to nonpartisan advocacy group Physicians for Reform, tort reform can further patient access to specialties like obstetrics, trauma surgery and neurosurgery while saving as much as $80 billion annually. In fact, a 2003 Health and Human Services report noted that medical liability reform can enable Medicare and Medicaid save up to $50 billion dollars annually.

In a recent survey conducted by Pinnacle Health Group about physician perception of the healthcare reform bill, 50% of its respondents considered malpractice reform as a critical factor for effectively practicing medicine. For an ER physician, "Tort reforms can help us decrease defensive medicine strategies. No tort reform means no separation of legitimate and frivolous lawsuits, which can further the cost of medicine. While congress cites malpractice insurance is only few percent of overall healthcare expenditure, it is the excessive use of healthcare resources due to defensive medicine that drives healthcare and doesn't get included in the equation. Rational use of healthcare resources can only come with tort reform."

Another physician commented, "Declining reimbursements without tort reform to contain physician expenses is untenable. Most single-payer models that other countries have that are so touted by politicians also include an assumption of medico-legal risks by the government rather than the individual practitioner. By not including these measures in the bill, it unfairly places the burden of medical costs on the physicians."

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QUICK SURVEY

PHG Surveys Physician Perception on the Healthcare Reform Bill (cont.)

medical care but not the deeper skills needed."

Another remarked, "If access is independent of responsibility, it will result in greater consumption and greater overall costs. This, along with increased time and expense to comply with regulatory oversight, will increase provider fatigue and degrade the quality of actual care delivered. I am at or near capacity now and cannot foresee how to do more with less."

Another physician commented, "The quality of medicine will likely decrease as it will possibly become financially untenable to sustain a practice with the impending reimbursement reductions and increasing overhead costs. Physician extenders will most likely shoulder some of the burden and the private practice of medicine as we know it will become obsolete and replaced with clinics with enormous wait times and less qualified practitioners."

WHAT IS THE DEMOGRAPHIC CLASSIFICATION OF THE COMMUNITY YOUR PRACTICE IS IN?	
Non-metropolitan (less than 50,000)	23.2%
Metropolitan (50,000—250,000)	29.4%
Metropolitan (250,001—1,000,000)	22.4%
Metropolitan (more than 1,000,000)	25%

Half of all surveyed physicians also consider malpractice / tort reform as a critical factor for effectively practicing medicine. For an ER physician, "Tort reforms can help us decrease defensive medicine strategies. No tort reform means no separation of legitimate and frivolous lawsuits, which can further the cost of medicine. While congress cites malpractice insurance is only few percent of overall healthcare expenditure, it is the excessive use of healthcare resources due to defensive medicine that drives healthcare and doesn't get included in the equation. Rational use of healthcare resources can only come with tort reform."

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Physicians are also optimistic about the bill. A Radiologist related, "At our locale, ER is way overboard with unnecessary procedures like CYA, defensive medicine, CT and other high tech imaging. If there were more in line we could shave the health care bill by about a third. What is it about more insured patients and less interference from the

In a recent study conducted by Health Affairs on defensive medicine (which is perceived as a driving factor for increasing healthcare costs) & its relationship with tort reforms, its study showed that a "10% decline in medical malpractice premiums would be less than 1% of total medical care costs in every specialty," although it does not recommend that it ignores its impact in healthcare costs and the physicians' emotional strain "because even this small level of extra cost should be eliminated from the system." In a separate survey, Health Affairs also noted that malpractice concerns were high among generalists and specialists in states "where objective measures of malpractice risk were low," and that there are relatively modest differences in physicians' concerns across states with and without common tort reforms."

PHYSICIAN RECRUITMENT

"Tort reforms also have an influence to physician recruitment," said Mike Broxterman, Chief Operating Officer of Pinnacle Health Group (PHG). "They attract doctors because they are perceived to be more physician-friendly, and they also tend to pay less in annual premiums than in other states. Its most evident case in point is Texas—by 2007 about 500 or so OB/GYNs were practicing in the state, and their malpractice premiums reduced by about 20%. Its positive domino effect for both Texas and the physicians is that it became a more attractive practice environment while more and more physicians were inspired to practice there."

PHG's Director for Training and Recruitment Craig Fowler remarked, "There is an implied connection to tort reforms, recruitment and retention, as there is perceived advantage of tort reforms for physicians. In West Virginia, for instance, its 2003 reform resulted in adding about 360 physicians the following year. Mississippi ranked the last in terms of physician supply, as doctors–particularly the younger ones, with specialties like OB/GYN and neurosurgery, relocated to other communities, but since its introdution of tort reform, Laurel and even Delta-based facilities are at least finding it easier to recruit physicians."

According to the Center for Delivery, Organization, and Markets Agency for Healthcare Research and Quality, counties with limited noneconomic damages had 2.2% more physicians per capita, while rural counties had 3.2% more; rural counties with a $250,000 cap had 5.4% more OB/GYNs and surgeons.

In a separate study by the Journal of American Medical Association (JAMA) in 2005, tort reforms had a

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TORT REFORMS SINCE 1986
from: Congressional Budget Office, The Effects of Tort Reform: Evidence from the States (June 2004); and the American Tort Reform Association, Tort Reform Record (December 31, 2003), pp. 2-3.

TYPE OF TORT REFORM	WHAT THE REFORM ENTAILED	STATES THAT ENACTED THE REFORM
Modify Joint-and-Several Liability	Formulated the amount for which a defendant can be held liable on the proportion of fault attributed. Formulas differed greatly between states, and most of the reforms applied to specific types of torts or had other restrictions.	AL, AK, AR, CA, CO, CT, FL, GA, HI, ID, IL, KY, LA, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, ND, OH, OR, PA, SD, TX, UT, VT, WA, WV, WI, WY
Modify the Collateral-Source Rule	Permitted evidence of collateral-source payments to be admitted at trial and allowed awards to plaintiffs to be offset by other payments, or both.	AL, AK, CO, CT, FL, GA*, HI, ID, IL, IN, IA, KS*, KY, ME, MI, MN, MO, MT, NJ, NY, ND, OH, OK, OR
Limit Noneconomic Damages	Caps ranged from $250,000 to $750,000; more than half of the reforms apply to torts involving medical malpractice.	AL*, AK, CO, FL, HI, ID, IL*, KS, MD, MI, MN, MS, MT, NV, NH*, ND, OH, OK, OR*, TX, WA, WV, WI
Limit Punitive Damages	Various types of limits included outright bans. Fixed dollar caps ranged from $250,000 to $10 million. It also capped equal to a multiple of compensatory awards.	AL, AK, AZ, AR, CA, CO, FL, GA, ID, IL*, IN, IA, KS, KY, LA, MN, MS, MO, MT, NV, NH, NJ, NY, NC, ND, OH, OK, OR, SC, SD, TX, UT, VA, WI.

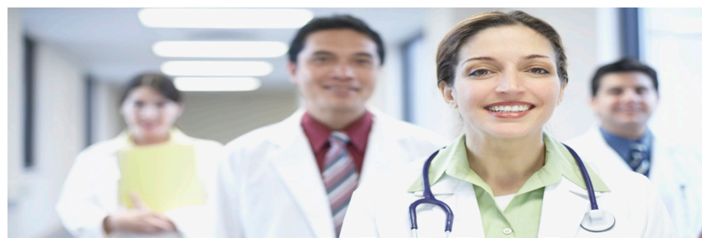
** The enacted laws since 1986 were found to violate the state's constitution.*

diametric relation to physician supply, which increased after enacting them for three years. The reform, according to the survey, had bigger impact on non-group and group physician supply, specialties with high malpractice premiums and communities with higher managed care.

MALPRACTICE IN OTHER STATES

Tort reforms in other states vary in their stipulations and / or provisions. In 2005, physicians saw the enactment of HB 393, Missouri's medical liability reform, which capped noneconomic damages to $350,000 and revised the state's malpractice rates among others. Premiums for ophthalmologists decreased to $16,406 in 2009 from $22,718 in 2006. However, Kansas' premiums for ophthalmologists were only $8,937 in 2009.

In Jefferson County, Mississippi, six claimants were awarded $150 million for asbestos-related cases last year—this led physicians to leave their practices



SUCCESS STORY

PHG finds Board-Certified Psychiatrist for a 241-bed hospital!

THE NEED:

This 241-bed facility is a major provider of advanced health and medical services in the Midwest, growing into 17 satellite centers and more than 1,750 employees. The facility recently lost a physician in their department and urgently needed a new doctor. This physician will also be tasked to build an outpatient practice, cover ED consults and manage patients on their inpatient service. Because of preferred balanced lifestyle among physicians, inpatient coverage / call responsibilities were seen as an added challenge in recruiting their new physician.

THE ACTION:

Pinnacle Health Group worked quickly in implementing a recruitment campaign with the hospital administrators. PHG made a first-hand community profile and personally toured the facility and the community to better assess what approach would work best.

PHG implemented direct mail campaigns using Digital Press and posting advertisements to online job distribution services as well as various print and specialty-specific publications. PHG also sought a bigger, yet quality, pool of physician candidates through niche venues and communicated with passive job seekers. After consultations and further assessments, PHG acquired many responses to these approaches, with online advertisements producing the best results. Like every successful placement, PHG regularly worked with the administrators and provided updates on the recruitment process.

THE RESULT:

There were issues over the facility's compensation arrangement because of the added inpatient consults, so Pinnacle Health Group met with the administrators and leveraged the practice opportunity by raising the base salary.

PHG was able to present a Florida-based physician who was greatly interested in the opportunity due to family-related reasons, particularly her college-age children studying near the community. Aside from a great personality, the client was impressed with her expertise and skills, particularly her willingness to accept higher inpatient consults.

After further site visits and negotiations, the hospital client hired the physician. With good communication, attention to detail and excellent negotiation skills, Pinnacle Health Group has yet again exceeded client requirements!

If you are interested in our recruiting services please contact Mike Broxterman, Chief Operating Officer, at 1-800-492-7771 or send him an email.

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insurance industry in the care we provide that is objectionable?"

A private practice doctor remarked, "In general, more coverage for more people will improve my practice, because I take care of many underinsured patients. The changes should balance out that discrepancy between practices. I think the healthcare reform bill is a step in the right direction. It is going to take some time, particularly with re-establishing a different hierarchy of care. There needs to be more emphasis on primary care medicine and incentives to encourage people to go into primary care practice." Another physician commented, "Expanding coverage from 85% to 95% isn't going to ruin medicine. In fact, it will assist my patients with life-threatening illnesses and avoid pauperization. All other industrialized societies have provided this coverage as has the insurance given to veterans and the US Congress. Underinsured Americans can eventually benefit."

WHAT AREAS / ISSUES DO YOU THINK WILL AFFECT PHYSICIANS IN RELATION TO THE HEALTHCARE REFORM BILL?
Note: Physicians were allowed to mark any options that apply.

Area / Issue	%
Compensation	91.6%
Administrative work	72.2%
Quality of care delivered to patients	77.4%
Patient volume / call coverage	64.4%
Malpractice	50.5%
People who will want to pursue medicine as a profession in the future	72.7%
Physician recruitment	54%
Physician retention	61.2%
Legal implications of the reform on practicing medicine	55.9%
Financial implications of the reform on my practice, i.e. reimbursements, overhead expenses	81.9%
The opportunity to advance in my career	29%
Declining practice setting	60.3%
Improving practice setting	9.1%

while 71 insurance companies closed down. As per the state's special legislative session, Mississippi's reform limits punitive damages and joint-and-several liability rules as well as restrict where cases can be tried and penalize attorneys who file frivolous cases.

In Florida, a physician-endorsed proposal to limit attorney fees was approved back in 2004. It included restricting initiatives by trial lawyers such as the "three-strikes" liability rule, which revokes a physician's license after having three liability judgments against them. There is also a recently passed limitations on intangible damages, which are capped between $500,000 for physicians and $750,000 for hospitals and non-physicians. However, they do not apply retroactively and are still challenged in the court.

Utah's tort reform placed a $450,000 cap on pain and suffering rewards—its newly passed law also requires patients to secure certifications from medical experts that would merit the claimant to pursue a case that could have been dismissed by a screening panel. Georgia's medical liability reform in 2005 capped claims to $350,000 against physicians and limited total awards to at least a million, where the case involves several physicians and hospitals. Nevada also capped its noneconomic damages to $350,000. In states like Illinois, South Carolina and Virginia, medical communities, particularly physicians, are pushing for a $250,000-cap on noneconomic damages—in Illinois, there is still pending proposals on protection for physician assets and change in expert witness laws.

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