Testimony of

Dr. Charles Sorenson, Jr.

August 20, 2004

Senate Committee on the Judiciary

"The Medical Liability Crisis and its Impact on Patient Care"

Huntsman Cancer Institute, August 20, 2004

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Thank you for the opportunity to testify today. My name is Charles W. Sorenson, Jr., MD, and I'm a urologic surgeon who has practiced in Salt Lake City for the past 22 years. I'm testifying on behalf of Intermountain Health Care ("IHC"), a not-for-profit integrated health care system serving the state of Utah and the surrounding Intermountain region. I serve as IHC's executive vice president and chief operating officer. Our organization includes 21 hospitals. While the majority of the 3,300 physicians who practice in our hospitals are independent practitioners, approximately 450 are employed by IHC's Physician Division. IHC also has a Health Plans division that offers four different types of managed care plans serving about 450,000 members. IHC is governed by some 300 local citizens who serve as unpaid, volunteer trustees. Our mission is to provide excellent health care to the residents of the communities we serve and to do so at the lowest possible cost. We take this responsibility very seriously, and we have received national recognition as an integrated delivery system that has demonstrated leadership in patient safety and continuous quality improvement initiatives.

I am testifying today on behalf of our trustees, our employees, and the patients we serve. In my testimony, I would like to offer the perspective of our regional health care system on the medical malpractice insurance crisis and on the need for federal tort reform.

First, let me describe to you the dimensions of the medical malpractice insurance crisis as we experience it here in Utah. In its assessment of the crisis in various states, the American Medical

Association has characterized Utah as an at-risk state; that is, a state that has not yet encountered the full dimensions of the crisis but a state that is showing problem signs indicating an impending crisis. IHC fully agrees with this assessment, and we are already seeing the negative impact of the crisis on patient care. Moreover, our experience is typical of the experience of other hospitals and health care organizations in our state. Like all Utah providers, we are currently experiencing the following symptoms of the emerging crisis:

1. Physician shortages and recruitment problems. We find it increasingly difficult to recruit physicians to practice in our hospitals in critical specialties such as neurosurgery, neurology, orthopedic surgery, trauma surgery, and cardiology. Physicians have become increasingly reluctant to take emergency call in the emergency rooms of our designated trauma centers. There is a significant amount of uncompensated care provided by both the physicians and the hospitals in these emergency rooms. This fact alone is a challenge for many physicians. The fact that these complicated trauma and emergency cases also bring with them an increased risk of malpractice claims makes the situation completely unattractive to many physicians. Some doctors ask the hospital to pay them to take call in the ER, despite the fact that hospitals likewise receive no funding from insurance companies or government for these patients. As some physicians relinquish hospital privileges to avoid ER duty, the burden increases on those who remain on staff. It is an unsustainable spiral.

Obstetrics is an area of major concern. As a growing number of physicians cease delivering babies, our patients are left with fewer and fewer options. The problem is evident in urban as well as in rural communities. For example, at our hospital in American Fork, seven family practice physicians have recently relinquished their OB privileges, citing as reasons the rising cost of malpractice insurance, the risks of litigation, and the inconvenience of late night call. We know of numerous other physicians in Utah who have made the same decision, adversely affecting patients in the Salt Lake Valley, Cache Valley, St. George, and other communities.

2. The training of new specialists. We are very concerned by trends reported by medical schools around the country, including the University of Utah, that indicate a dramatic decrease in the number of students who are pursuing residencies in surgical and other high-risk specialties such as those mentioned previously. Clearly these are very demanding professions, requiring long years of postgraduate training and many interruptions of personal and family time in order to care for emergency patients at every hour of the day, every day of the year. These facts alone are significant detractors for many students. But others who would enjoy the challenge and rewards of these intense specialties turn to other fields when they come to understand that they would be exposed to a very high risk of malpractice litigation--even when practicing at an exemplary level. They are very aware that, in these specialties, even the best of the best are repeatedly dragged into expensive, time-consuming, and emotionally wrenching litigation.

3. Escalating health care costs because of defensive medicine. This phenomenon has been widely recognized in the medical literature for years, and it is not going away. At IHC we have made significant strides in helping physicians understand best clinical practices as recognized by evidence-based clinical trials and national specialty groups. It is impossible, however, for clinicians to ignore the reality of the medical liability environment in which they practice, and far too many diagnostic studies are ordered or interventions performed not because they make the

best sense clinically, but because they might protect the physician in case of a later lawsuit. Many commentators have recognized that the United States has higher health costs per capita than many other countries with a comparable standard of living. How much of this difference is due to the unique tort laws we have in the United States, which often frighten physicians into over-evaluating and over-treating their patients?

4. Escalating legal expenses. IHC's litigation expenses have gone up by more than 300 percent in the last 10 years, even though our clinical quality is demonstrably excellent, our risk management program has been recognized as one of the best in the nation, and medical malpractice claims against us are extremely rare. (Fewer than one-hundredth of one percent of our 6 million annual patient encounters result in a malpractice claim, and virtually all of these claims are resolved out of court.) Yet we incur costs to defend ourselves even when we are ultimately dismissed as parties to lawsuits due to lack of cause. It has become customary and routine to name hospitals in malpractice lawsuits brought against physicians, regardless of the facts of the case, simply because hospitals are viewed as having "deep pockets." IHC's experience is typical of most hospitals in this respect. We are greatly troubled by these escalating legal expenses--much of which are incurred to defend ourselves against claims that are ultimately judged to have no merit. Obviously, we would much rather spend that money on improving patient care or on reducing our charges to the patients we serve.

5. Escalating malpractice insurance expenses. IHC provides malpractice insurance to its employed physicians and to its hospitals, clinics, and other facilities. In order to provide this insurance in the most cost-effective way, we self-insure up to a certain level of coverage. We benchmark our costs in this area against other excellent organizations, and continually strive to control these costs. Yet despite these efforts and a favorable claims record, our malpractice insurance expenses have increased by 136% in the last seven years, driving up costs to payors and diverting resources from patient care.

So IHC and other organizations in Utah are already experiencing serious symptoms of the medical malpractice insurance crisis. It is adversely affecting patient care in our state in terms of decreased availability of certain key physician specialties, increased costs of liability insurance and legal work, and increased costs of defensive medicine.

Now I'd like to address two analyses of the crisis that are frequently made by opponents of reform efforts.

The first allegation is that the medical malpractice insurance crisis is largely due to widespread incompetence in the practice of medicine. In our experience, this allegation is absolutely inconsistent with the facts. As I previously noted, our organization has been widely recognized not only for the excellence of its care and medical outcomes but also for our pioneering efforts to systematically improve patient safety and to raise the standards of clinical excellence.

IHC has focused on clinical quality for years. We have been fortunate to have leaders within our organization like Dr. Brent James, our vice president of Medical Research at IHC and executive director of the IHC Institute for Health Care Delivery Research. Dr. James has an international reputation in the application of continuous quality improvement techniques to the field of health

care. Through the IHC Institute, he has helped train thousands of physicians, nurses, and other clinicians in the use of clinical quality improvement techniques. Dr. James also serves on the Institute of Medicine's National Roundtable on Healthcare Quality and its Committee on Quality of Healthcare in America. He was a member of the IOM committee that produced the two landmark reports on patient safety: To Err Is Human (1999) and Crossing the Quality Chasm (2001).

The work of Dr. James and of many other clinical leaders is reflected in IHC's six clinical programs and our system-wide Patient Safety Initiatives. These programs create annual goals for clinical quality improvement in areas such as Cardiovascular Services, Cancer Services, Women and Newborns Services, Primary Care, Behavioral Health, and Intensive Medicine. Our programs have resulted in medical outcomes that rank among the best in the nation. We recognize that we still have much work to do, and we will not feel satisfied until every patient receives best care in every encounter. But much has been accomplished, and my point is that even though IHC has one of the most impressive records of clinical excellence and patient safety in the nation, we, like other medical institutions, are still experiencing the damaging effects of the malpractice insurance crisis.

A second allegation often made by opponents of reform is that the precipitous rise in medical malpractice insurance rates is due to profit-seeking by insurance companies. The allegation is that the rates have been increased artificially to cover declines in investment income. This allegation, too, is inconsistent with the facts in Utah, where the insurance companies that provide most of the medical malpractice insurance are efficiently managed and not-for-profit.

Roughly 4,300 physicians practice in Utah, and most of these physicians obtain their malpractice insurance through the Utah Medical Insurance Association (UMIA), a not-for-profit company affiliated with the Utah Medical Association (UMA). Most of the physicians not insured through UMIA are employed by one of the state's two major not-for-profit systems, the University of Utah Hospitals and Clinics or IHC. Both of these organizations self-insure for malpractice claims. UMIA, the University of Utah Medical Center, and IHC all seek to provide malpractice insurance at the lowest possible rates. Yet even in Utah, malpractice insurance premiums are skyrocketing at rates of 20% to 60%--or higher--annually. For example, average premiums for Utah ob/gyns have increased 94% in last four years, from $42,000 in 2000 to $81,628 in 2004. [Source: Utah Medical Insurance Association.]

The problem of escalating premiums is especially acute for physicians in rural Utah, who have fewer patients among whom to spread the increasing cost of malpractice insurance. It is making it especially difficult for family physicians in rural areas to deliver babies. We are very concerned that unless significant changes are made, some communities in Utah will be without obstetrical coverage due to the malpractice insurance crisis.

Thus, neither of these two allegations regarding the causes of the malpractice insurance crisis is consistent with the facts or with the experience here in Utah.

Now I'd like to offer our perspective on possible solutions to the crisis:

1. Tort reform. Even though Utah has been one of the most progressive states in the U.S. in

implementing tort reform legislation, we nevertheless continue to experience the ill effects of the malpractice insurance crisis. For example, over the years, the Utah legislature has supported the following concepts and approaches with respect to resolving medical malpractice disputes:
? Prelitigation panels. These hearings provide opportunities to resolve differences and work through issues prior to going to court. In Utah, prelitigation panels are required by state law as a step in the court litigation process.
? Collateral source doctrine. If plaintiffs have already received compensation from other sources, that is taken into account in awarding damages.
? Comparative negligence doctrine. If a plaintiff is found to be more than 51% liable for damage incurred--that is, is mostly responsible for his or her injury--then the plaintiff is not permitted to recover damages from other parties.
? Statute of limitations on malpractice claims. Plaintiffs must file claims within two years of the event or of becoming aware of damage. (Minors have until age of majority to file claims.)
? Structured settlements policy. This policy ensures settlement money is available to the plaintiffs as needed over time and protects against "windfall" awards that might be squandered.
? Caps on non-economic damages (e.g., "pain and suffering"). These caps have been in place in Utah for many years, but several factors have reduced their effectiveness. Several years ago the caps were indexed to economic indicators, and currently the cap is about $410,000. This is significantly higher than the cap on non-economic damages in California. Furthermore, Utah's cap has not yet withstood challenge in the state's Supreme Court. If it is ruled unconstitutional in a current case before the court, many predict that professional liability rates in Utah will rise dramatically, further reducing access to critical health care services in our state.

We believe that federal laws that are consistent nationwide and able to withstand challenges at the state level would be helpful in correcting abuses and perverse incentives in our current tort system. Consistently applied national limits on non-economic damages would be especially helpful.

2. Alternative dispute resolution ("ADR") methods such as mediation and arbitration may have the potential to slow the increase in malpractice expenses, but will be difficult to implement widely. Such methods will likely only be effective if a critical mass of patients agrees to use them. Unfortunately, IHC's experience suggests achieving a critical mass may not be possible on a voluntary basis and that mandating the use of ADR methods is extremely unpopular.

In 2003, at the urging of the Utah Medical Association and most Utah physicians, IHC supported state legislation allowing physicians, as a condition of provision of non-emergency medical care, to require their patients to agree to use arbitration to resolve medical malpractice disputes. Evidence suggested that arbitration was faster, less expensive, and just as equitable as the traditional court litigation process. The Utah legislature enacted such a law, and a large percentage of Utah's independent physicians began using mandatory arbitration in their practices. At the urging of its employed physicians, IHC's board approved the use of mandatory arbitration agreements in some of our Physician Division clinics in late 2003. We did not believe this would significantly decrease our medical liability costs, but we did believe that it would decrease the lengthy time required to resolve disputes through the courts, decrease the percentage of dollars wasted in an adversarial legal system, and increase the dollars available to compensate victims of medical error. Considerable public resistance developed, however, to the concept that physicians

could refuse to care for patients who did not sign arbitration agreements, and the 2004 legislature revised the law. IHC's Physician Division clinics now encourage--but do not require--patients to agree to resolve any disputes through arbitration.

In summation, may I offer these concluding thoughts:

1. The medical malpractice insurance crisis in our nation is real and is already adversely affecting the delivery of care in Utah and other states. Growing numbers of patients are finding their access to care limited.

2. The primary cause of the crisis is that traditional tort litigation is a clumsy, expensive, and often inequitable instrument for the resolution of complex medical malpractice cases. In our current system, limited financial resources are too often consumed by the legal process rather than used to compensate injured patients.

3. The allegations that the crisis is primarily due to incompetent medical practitioners or to profit-seeking insurance companies are not supported by evidence.

4. Federal limits on non-economic damages are a promising method to address the medical malpractice insurance crisis. Alternative dispute resolution processes such as arbitration may also have potential to mitigate the problem and should be encouraged on a voluntary basis, but in our experience, efforts to mandate such ADR processes have been extremely unpopular with the public.

5. Providing medical care is an extremely complex undertaking in which each patient is, to some degree, unique and each procedure is a "customized" procedure. In any field of human endeavor, some error is inevitable. Even in the best medical institutions, medical error will occur, and we all agree that patients who have been injured should be fairly compensated. The challenge is to develop an optimal process for making such compensation, and to reduce the huge number of dollars wasted in an inefficient tort system and in the practice of "defensive medicine."

IHC believes our traditional system of court litigation can be improved and that medical liability reform is sound public policy. On behalf of our volunteer trustees, our employees, and the patients we serve, I thank the committee for the opportunity to provide input on this important topic.

Respectfully submitted,

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