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Malpractice rates plateauing

By Beth Thomas Hertz

The only thing to fear may be fear itself

Sonia Rapaport, MD, of Chapel Hill, North Carolina, believes her malpractice insurance rates are very reasonable. Rapaport, who is double-boarded in family practice and holistic medicine, adds that she is very fortunate to have coverage—about $3,000 per year through the American Medical Women's Association.

"Teaching empathy and listening is so important for physicians who have been sued for malpractice, especially if they have been sued more than once. Patients who feel they have been heard are much less likely to sue." —Sonia Rapaport, MD

Lee J. Johnson, JD

Although physicians may argue over the definition of "reasonable," they often cite malpractice insurance as one of the expenses that continue to inflate the cost of healthcare. Many physicians practicing in the United States today, however, are finding that their rates are stable or have decreased from 2009 to 2010.

This plateau was seen in *Medical Economics*' 2011 Exclusive Malpractice Survey, continuing a pattern that has emerged in recent years. The survey, conducted via the Internet in June, also examined physician earnings (*Medical Economics*, September 25, 2011, issue) and productivity (*Medical Economics*, October 10, 2011). More than 5,000 responses were included from physicians who indicated that they are actively practicing and that their primary field is not academic/research. From these, 4,200 respondents were randomly selected for final tabulation.

Premiums by age

Age in years	Median annual premium
Under 30	$7,500
30 to 34	$11,200
35 to 39	$14,400
40 to 44	$15,500
45 to 49	$16,700
50 to 54	$15,700
55 to 59	$15,200
60 to 64	$14,100
65 or more	$12,200

Premiums by age

When participants were asked to evaluate their total 2010 malpractice premiums, one in six (16%) said they increased from the previous year, 39% said they stayed the same, and 11% reported a decrease. Of the remaining participants, 29% indicated they did not know because their premiums are paid for them, and 6% didn't know for unreported reasons or did not answer the question.

Premiums by hours worked

Hours worked per week	Median annual premiums
30 or fewer	$8,600
31 to 40	$12,200
41 to 50	$13,900
51 to 60	$17,100
61 to 70	$17,800
71 to 80	$26,400
81 to 90	$21,400
90 or more	$22,000

Premiums by hours worked

In the 2010 survey, 37% reported their rates were unchanged, 19% reported an increase, 11% reported a decrease, and 31% did not know.

Among those who did answer in the 2011 survey, the mean amount was $24,500 and the median was $14,700.

Accounting for the disparity between these two statistics were reports at the high end of the distribution—8% indicated their premiums were $50,000 or more, including 2% at $100,000 or more.

Among those reporting an increase, the average amount was $4,720 and the median amount was $2,350. Among those reporting a decrease, the average amount was $4,150 and the median amount was $1,770.

Family and general practitioners reported median premiums of $12,100, down slightly from $12,600 in 2009. Internists' median was $13,100 (down from $14,500 in 2009) and pediatricians' rates were $11,800 (up slightly from $11,500 in 2009). Ob/gyns, always at the high end of the primary care spectrum, paid a median of $46,400, down from $51,200 in 2009.

Median premiums reported by specialists:
- Plastic surgeons: $30,000
- Cardiologists: $24,000
- Urologists: $22,500
- Emergency/acute care practitioners: $20,000
- Neurologists/neurosurgeons: $20,000
- Gastroenterologists: $17,900
- Hospitalists: $13,700
- Ophthalmologists: $12,800
- Dermatologists: $10,300
- Psychiatrists: $7,700

HIGHER PREMIUMS

Higher patient volumes are closely linked with higher premiums, with the highest rates being reported by physicians seeing 175 to 190 patients per week ($17,500). This finding was followed by those seeing 150 to 174 patients per week ($16,700) and those seeing 200 or more ($16,400). Physicians seeing fewer than 25 patients per week ($9,000) reported the lowest rates.

Premiums by community type

Community type	Median annual premiums
Inner city	$18,200
Urban	$14,500
Suburban	$15,400
Rural	$13,000

Premiums by community type

Similar patterns were seen when results were sorted by number of hours worked per week. Physicians logging 71 to 80 hours per week paid the most, $26,400, whereas those working 30 hours or less paid just $8,600.

Premiums were highest among physicians who have been in practice for 11 to 20 years ($16,500), followed by those in practice for 6 to 10 years ($15,900) and 21 to 30 years ($14,900). They were lowest for those practicing 2 or fewer years ($10,000) and those who have practiced more than 30 years ($12,900).

Premiums by geographic region

Region	Median annual premiums
Northeast	$20,100
South	$13,600
Midwest	$14,500
West	$13,600

Premiums by geographic region

By physician age, the highest premiums were seen among those aged 45 to 49 years ($16,700) and 50 to 54 years ($15,700), then 40 to 44 ($15,500). Lowest rates were seen among those aged fewer than 30 years ($7,500).

Lee J. Johnson, JD, a health law attorney in Mount Kisco, New York, and a *Medical Economics* editorial consultant, says that this trend is likely due to the fact that physicians are paying claims-made insurance, not occurrence insurance. These rates will be higher after the policy is in effect a few years. She adds that younger doctors will have cleaner slates in terms of reporting of incidents. After time passes, the doctors would be paying for claims that have occurred and also been reported. When doctors retire, they may only pay for tail coverage, or get it at no cost, which could account for the decrease of payment in later years.

When analyzed by community type, the highest premiums were found among doctors practicing in the inner-city ($18,200), followed by suburban ($15,400), urban ($14,500), and rural ($13,000) settings.

Johnson says that rural physicians are often seen as part of the community, making patients more hesitant to sue them. Inner-city physicians are less likely to have such a bond with their patients and are more likely to be specialists who treat complicated problems and perform high-risk procedures, both of which raise rates. Also, urban residents may just be more litigious than residents of rural areas, she adds.

NORTHEAST COSTLY

Premiums by practice size

Practice size	Median annual premiums
Solo	$13,600
Expense-sharing	$14,700
2 physicians	$15,900
3 to 10 physicians	$17,200
11 to 25 physicians	$18,000
26 to 50 physicians	$16,900
More than 50 physicians	$13,800

Premiums by practice size

By region, premiums were by highest in the Northeast (median, $20,100), followed by the Midwest ($14,500). The South and West tied at $13,600. Edward Lawyer, MD, who practices in Hoboken, New Jersey, says that higher premiums in the Northeast are related largely to the medical malpractice environment there.

"There is a reason people in New Jersey who are on Medicare have higher numbers of consults on admission and at end of life," he says. "Doctors are scared of malpractice claims. State laws and the general environment encourage this. Healthcare is just more expensive here in general."

Premiums by patient volume

Number of patient visits per week	Median annual premiums
Fewer than 25	$9,000
25 to 49	$12,500
50 to 74	$14,900
75 to 99	$15,100
100 to 124	$15,200
125 to 149	$15,600
150 to 174	$15,700
175 to 199	$17,500
200 or more	$18,400

Premiums by patient volume

Premiums by years in practice

Years in practice	Median annual premiums
2 or fewer	$10,000
3 to 5	$14,300
6 to 10	$15,900
11 to 20	$16,500
21 to 30	$14,900
More than 30	$12,900

Premiums by years in practice

Lawyer, who practices emergency medicine in a 20-physician group, says the group's premiums have increased slightly. He believes the reason emergency medicine physicians pay higher rates than office-based practitioners is because they must make decisions quickly and with limited information.

"Also, they do not have an established doctor-patient relationship," he says.

Lawyer adds that his group, which operates in a mid- to large-sized community hospital, would hire another physician or nurse practitioner, but the malpractice rates are prohibitive.

"We have the volume and the need to hire, but the costs of adding someone and the costs of insurance in general are limiting our ability to do it," he says.

The simple reason, according to Johnson, is that the Northeast is traditionally more litigious, having both a higher frequency and a higher severity of claims. Malpractice insurers are actuarially covering those odds.

Premiums for primary care doctors

Physician type	2009 median annual premiums	2010 median annual premiums
FP/GPs	$12,600	$12,100
Internists	$14,500	$13,100
Pediatricians	$11,500	$11,800
Ob/gyns	$51,200	$46,400

Premiums for primary care doctors

TEACH EMPATHY AND LISTEN

Rapaport offers what she calls a "listening-based practice" in which she routinely sees patients for an hour or more. The solo practice, Haven Medical, offers primary care, consultations, and medical chart reviews for children and adults. It does not accept insurance.

Often she sees patients who have had bad experiences with a past practitioner and believe they are correct in wanting to sue. "I always say, 'Let's talk about your health instead,' " she says.

"Too often, lawsuits are a way of getting back at people who have hurt you," says Rapaport, who has considered becoming a consultant for practices that have been sued.

"Teaching empathy and listening is so important for physicians who have been sued for malpractice, especially if they have been sued more than once," she says. "Patients who feel they have been heard are much less likely to sue."

Rapaport sees patients frequently who have fled a previous practice because their doctor was so focused on practicing defensive medicine that the doctor became highly annoyed when a patient did not follow the advice he or she was given. For example, a hypertensive patient's refusal to take his or her blood pressure medication can lead to considerable tension between the doctor and the patient to the point where the patient leaves, or is asked to leave, the practice.

"It destroys the doctor-patient relationship when a doctor becomes subservient to the risk of malpractice," Rapaport says. "The doctor stops listening and becomes disrespectful to the patient. It kills the relationship because there is no trust. But the irony is that once that trust is gone, they are actually increasing their chance of being sued."

She believes the fear of being sued further hurts patient care as physicians feel compelled to document superfluous information and as new privacy laws constrict their actions.

"If a family member calls with additional information about a patient, I cannot talk to them," she says. "Sometimes, this prevents us from making the best decision for the patient."

AVOIDING A SUIT

Johnson agrees that better patient communication and trust are the keys to avoid litigation.

"There are two elements that must go into the decision to sue," Johnson says. "The patient has to have suffered unanticipated or severe damage. Plaintiffs' lawyers may want to take such cases regardless of who is at fault. Also, you have to have an angry patient who wants a forum to vent his or her complaints."

Too many physicians learned their communication skills many years ago and struggle to change their ways now, she says. "It is harder to change that than improving documentation."

Johnson recommends that practices have on-site assessments, which are sometimes paid for by insurers, to look for red flags that could predispose them to lawsuits. Such reviews would examine office procedures as well as prior claims and identify malpractice risks. She also strongly cautions physicians against buying the least expensive malpractice insurance policy they can find.

"Companies might seem to be competing, but if they are not charging enough, they might go out of business," Johnson says. "Premiums are not controlled by the marketplace as much as you might think. They should be controlled by actuarial data. Usually, there is a reason for low rates, and it might not be a reason you can live with."

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"WE ARE DESTROYING PHYSICIANS"

Stephen May, MD, who practices family medicine in Elizabethton, Tennessee, was sued for malpractice about 2.5 years ago—the first time in his 25 years of practice. An 18-year-old girl whose family had been treated by May and his relatives (12 May family members practice medicine in the area) for decades was seen with a recent onset of mild numbness in her left hand after a negative workup in the emergency department. With no history of trauma, May did not pursue a full battery of tests. The patient proceeded to suffer a spontaneous carotid dissection, however, and the subsequent stroke left her disabled. His part of the litigation was deemed to be only 5% of a total settlement, and his legal counsel encouraged him to settle.

"There was nothing anyone could have done to prevent this for her," May says. "It was not a preventable situation, and [my lawyers] felt my role was very defensible, but paying a little to make it go away was seen as a better option. I

truly regretted doing it."

"The cost to your family, to your practice, and to your soul is enormous. I just wanted to be able to tell my wife and kids it was over," he explains. "Nobody takes that into account when they talk about malpractice.

The experience has dramatically changed how May and his relatives practice medicine. Before the suit, he was among the top 10% of physicians in his area for cost-effectiveness based on his insurance grade cards. Today, his referrals to specialists are up 350% and he orders 550% more tests.

"I used to diagnose and treat most patients myself, but now I have lost my confidence," May says. "Now, I consider that it could be x or y or z, and I start looking. I used to start a workup at one visit and finish it at a later time. Now, I explore the full differential diagnosis and order a full battery of tests on the first visit so I am not missing a 'zebra.' "

This way of practicing not only increases healthcare costs, but it also costs him additional time, because he must review and interpret all the test results that are generated, decreasing overall productivity.

REVERSE ITS DENIAL

A further change to May's practice is that he, his brother, and his father added a $125,000 electronic health records system to better track patients as well as a computer callback system to follow up if lab results aren't returned promptly. They record every insurance company denial for care and tell the company representative that their denial is being noted in the record should there be a malpractice claim. (He has seen this bluntness cause a company to reverse its denial.) Practicing such defensive medicine helps him to sleep better at night, he explains.

"No one talks about the posttraumatic stress syndrome doctors can experience," he says. "I have a recurring nightmare where I cannot find what is wrong with a patient and I am facing a pass-fail grade. I wake up in a cold sweat."

May now sees patients in his office only for 3 hours a day, having taken a full-time public health job and overseeing a 100-bed nursing home. He no longer does hospital work.

"My heart has changed," he says. "My nurse has a saying: 'Remember, they are your patients, not your friends.' Accepting that has broken my spirit, but I have had to do it."

May's vision for improving the malpractice situation includes removing lawyers and lay jurors from the process and instead taking disputes to a medical review board that can determine whether the physician deviated from the standard of care and whether that deviation led to the alleged harm. If the board finds the physician to be at fault, the physician should be sent back for additional training and examination. Patients would be entitled to receive compensation only for actual damages based on the national disability scale, he envisions.

"Right now, we are destroying physicians, even though each one represents a $250,000 investment in training," he says. "You can't change the cost of medicine until you change the malpractice laws and the unrealistic expectations of patients."

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