

*ACMPE Paper, October 2006*

## **The Rise of Physician-Owned Medical Malpractice: Necessity Breeds Invention**

By: **Karen Massey, MHA, FACMPE, CPMSM**

This historical paper manuscript is submitted in partial fulfillment of the requirements for election to Fellow status in the American College of Medical Practice Executives

This manuscript was prepared as part of meeting various recognition criteria as set forth and may be changed from time to time by the American College of the Medical Practice Executives (ACMPE). The experiences, thought, ideas and opinions set forth are solely those of the author.

They do not reflect any position on the part of ACMPE with respect to their completeness, correctness or accuracy of the paper's contents, for example, on points of law or accountancy in effect at the time of or subsequent to the date of paper completion.

### Introduction

Few issues galvanize physicians as much as medical malpractice insurance and litigation.

Some physicians have resigned themselves to the fact that their involvement in medical malpractice claims are simply "a cost of doing business" and liken their experiences to theater played out by attorneys. Others, however, remain committed to the idea of reducing risk for patients and creating fairness in the injury and compensation arena.

Regardless of the physician's view, there is no doubt that the medical malpractice market over the last several years has been the focus of national headlines. Many argue that we are passing through the latest "hard market" into a period of more stable pricing.<sup>1</sup> And while this may be true, frustration lingers at the cyclical nature of the markets and the seeming "disconnect" between a physician's actual malpractice history and malpractice insurance pricing.

This paper seeks to explore the historical background of medical malpractice and the rise of the physician-owned malpractice solutions. Through this historical perspective and an understanding of the differences between the physician-owned and investor-owned insurers, the reader will understand the market forces that may continue to increase the popularity of the physician-owned model. This perspective is achieved through existing written and electronic literature, interviews and the author's personal experience.

Physicians have a long history of autonomous behavior so it should be no surprise that the increasingly frustrating state of the medical malpractice market would spur action on the part of physicians.<sup>2</sup> An important and highly visible outgrowth of this response has been the focus on tort reform at the national and state level. Behind the scenes, however, decisions have and are being made within physician groups around the country that are changing the landscape of the medical malpractice insurance market. In summary, tort reform has been the public policy response to the crisis, and the move to physician-owned medical malpractice insurance has been the private, market-based response.

This market-based response is not new. Physician-owned medical malpractice has been around since 1975. In fact, sixty percent (60%) of the nation's physicians retain their medical malpractice insurance through some type of physician owned company.<sup>3</sup> We are now operating in an environment that is not solely characterized by the dominance of the familiar names of St. Paul, AIG (American International Group) and other large commercially owned malpractice insurance carriers. While these carriers certainly

remain strong in some markets, others, such as St. Paul in 2001, have left the business of medical malpractice insurance completely.

### Genesis of Medical Malpractice Insurance

Understanding the beginning of medical malpractice is useful in making sense of our current challenges. Medical Malpractice as a known legal concept began in the United States in the early 1930s. While there had been a handful of cases in England and France relating to midwifery care, the first case in the United States was in 1832. Although England did not have a high frequency of cases, they had enough to create a foundation for the legal concept of Medical Malpractice. The frequency of medical malpractice cases quickly accelerated, however, in the thirty year period from 1835 to 1865. In those thirty years, the Boston Medical and Surgical Journal reported 48 medical malpractice cases. Soon the journals of the day were abuzz with discussion and commentary of this new phenomenon.<sup>4</sup>

Early cases in the United States were characterized largely by the medical care of fractures and amputations. In 1850, Doctor James Webster began his anatomy course at the Geneva (NY) Medical College by advising physicians “to refuse fracture cases among the poor and that judicious witnesses should be present when surgeons treated patients to record what happened and to keep independent case records.”<sup>5</sup> This advice was the result of the perceived increased propensity for lawsuits among the poor. Historically, the clinical expectations regarding the aftermath of a fracture (typically amputation or deformity) were minimal, but with the onset of actual treatments – expectations of

miraculous recoveries skyrocketed. Interestingly, the advice given in 1850 regarding consents and documentation remains paramount in the defense of medical malpractice accusations today.

Unlike our current environment, the early days of medicine were characterized by an absence of regulation and licensure. Medical training was varied and ranged from what we now know as the roots of modern medicine to all manner of alternative healers and charlatans. Distinctions were not clearly drawn between medical doctors as we know them today and physicians who obtained degrees in as few as three months. Ironically, the more advanced physicians were more likely to be sued. This was a function largely of more experienced physicians attempting new procedures to save limbs rather than the established practice of amputation. When the results included deformity or other untoward outcomes, patients often responded with litigation. The legal risk to the more experienced, or classically trained physicians was also a function of a more common body of knowledge. Since there was some consensus with regard to the appropriate treatments as taught in training, there was also an opportunity to point out those who practiced outside of the generally accepted norms. It wasn't until the end of the 19<sup>th</sup> century that even approximately 90% of physicians were trained in a generally accepted format so varying experience was a factor in medical malpractice cases for some time.<sup>6</sup>

During this period of early jurisprudence in medical malpractice, the courts had set the standard of care in each community as the threshold for determining whether or not malpractice resulted from the physician not meeting this local standard of care as

espoused in the “locality rule.” Further, local medical communities became close knit due to the “locality rule” which required that the expert witnesses be from the local community in order to be able to testify to this local standard of care. The local nature of these early cases resulted in medical societies making malpractice defense a direct service.<sup>7</sup> As a response to this threat to the physician’s livelihood and assets, physicians turned to medical society legal defense funds, mutual defense pledges and eventually malpractice insurance. One can only imagine the uphill battle faced by a plaintiff taking on essentially the majority of the local medical community to prevail in a suit. Additionally, it became of paramount importance to the individual physician to belong to the medical society due to the collegial nature of malpractice defense.

Some of the issues that were first raised in this surge of medical malpractice cases have not dissipated such as the lay person’s sense that a bad outcome is the result of malpractice. Other issues present in the early 1800’s, however, have been mitigated. The regulation by state licensure agencies as well as the uniform credentialing of physicians practicing at JCAHO (Joint Commission on Accreditation of Healthcare Organizations)—accredited facilities has reduced the ability of non-qualified physicians to practice medicine on an unsuspecting public.

The early history of medical malpractice insurance was not unlike that of health care insurance in that it was inexpensive and widely available. The premiums were a pittance for the unlikely nuisance of a malpractice case. And so it became the norm that each physician would carry such insurance and the medical community grew to accept this as

commonplace. It wasn't until the late 1970's and 1980's that hospitals in most communities began requiring medical malpractice coverage of the physicians on their medical staff as a condition for privileges.<sup>8</sup> Since most malpractice cases involve the naming of all parties involved in the care of the patient (some of which may be dismissed at a later date), hospitals have made this a requirement to make sure that they are not the lone defendant with "deep pockets" in the event of an adverse verdict. By requiring the medical staff to maintain medical malpractice insurance, hospitals hope to contain their financial exposure to this risk.

### An Environment for Change

The history of the malpractice insurance market in the United States has been characterized by periodic pricing crises. With each crisis, physicians ask: "Is there a better way?" - - and they seem to ask a little louder each time. The issue of these crises warrants its own exhaustive review and many have been done. It is germane to this topic; however, to have an understanding of these crises, their causation and the elements of the market that still require reform and/or mitigation through the physician-owned malpractice model.

The first crisis of our contemporary time began in the 1960's as tort law became more liberal and increases in claims and losses followed. In 1971, President Nixon directed the first governmental study of the problem. This study found "no crisis" due to the continuing availability of insurance, albeit at a higher premium.<sup>9</sup>

The crisis escalated and peaked in 1974 when some insurers withdrew from the market. In 1975 the State of California enacted the Medical Injury Compensation Reform Act (MICRA). The principal elements of MICRA include a cap of \$250,000 on non-economic damages, evidence of collateral source payments, limits on attorney contingency payments, and periodic payments on any assessed damages. MICRA did stabilize the California market and it would be years before hindsight demonstrated just how effective MICRA had been. In the present crisis, some states have passed “MICRA type” legislation to address the unstable markets.<sup>10</sup>

Against this backdrop, the first physician-owned company came into existence in 1975.<sup>11</sup> In the late 1970’s interest rates rose again allowing insurance companies to earn more on their investments and many of the traditional line insurers returned to the medical malpractice insurance market.

In the early 1980’s interest rates were again low and defense costs were rising. In response, premiums rose and the next crisis was on. This familiar set of dynamics coupled with escalating defense costs and jury awards prompted some states to legislative action. Again in the late 1980’s, the market returned to a relatively steady state.

From 2001 to 2005 the dynamics were back, but exacerbated by some staggering jury awards which were cited by St. Paul, heretofore one of the largest carriers in the market, when they discontinued the medical malpractice insurance line. The market had become so bad in 2001, that Jay Fishman, the chief executive of St. Paul said that staying in the

malpractice business “would threaten the solvency of the company.”<sup>12</sup> Also notable with regard to this crisis were the rising defense costs and jury awards. From 1997 to 2003, the median jury award in medical liability cases nearly doubled from \$157,000 to \$300,000. In cases that were dropped or dismissed, the average cost to the defendant was \$17,408 and for those in which the defendant prevails at trial, the defense cost was \$87,720 in 2003<sup>13</sup>. While some make the argument that the insurance companies are getting rich, the combined loss ratio in 2003 was actually 137.5 which means that for every dollar of premium, the insurance companies were paying out \$1.375 in medical malpractice defense costs, judgments and settlements. <sup>14</sup>

#### Types of Medical Malpractice Insurance Companies

A review of the types of medical malpractice insurance companies is helpful to an overall understanding of the current malpractice insurance market and the opportunities for the alternative models which were employed by the physician-owned companies.

Until the recent surge in physician-owned insurance, the most common type of insurance carrier for medical malpractice had been the “traditional line” companies. These companies are characterized by a wide range of insurance products – medical malpractice being only one type. These companies were, and continue to be, favored by those who like the assurance of a typically large company that is regulated and insured by each state in which they write policies. As noted, it can be particularly painful for the physician customers when one of these companies leaves the medical malpractice market such as St. Paul did in 2001 since these companies are usually large and leave a large number

uninsured when they leave the market. Their large number of policy holders, left in the wake of market departures, are not easily absorbed by the remaining insurers.

Captive insurance companies are wholly owned subsidiaries of an entity or group that comes together to become an insurance company.<sup>15</sup> Unlike the traditional line companies, the sole purpose of a captive is to cover the insurance exposure of its entity and its members. In health care, there are physician captives, but more commonly captives are found among large institutional providers such as hospitals.

In the 1970's some states and medical societies began to operate Joint Underwriting Associations or Mutuals. These were not-for-profit associations designed to spread risk among the insureds to ensure the availability of insurance. These were somewhat problematic, however, because they were designed to be self-sufficient. To that end, they would sometimes find it necessary to make retroactive assessments to cover claims.

In 1986 Congress passed the Liability Risk Retention Act which allowed physician-owned companies to flourish. A risk retention group (RRG) allows self-insurance for the provision of professional liability insurance. The Act also delineates that the company must have as its primary purpose the spreading of liability risk and not the purpose of making a profit. RRGs, as defined by the Act, are corporations or limited liability partnerships that are organized for the purpose of assuming and spreading liability risk amongst its members. While the RRG must be incorporated and licensed in at least one state, the Act permits the RRG to solicit business and write insurance in the other states.

While not all RRGs are specialty specific (many insure a range of medical specialties), the ability to sell across state lines was critical to the continuing rise of specialty-specific physician-owned insurance. Few states have enough of a particular medical specialty to spread the risk enough to make a viable insurance proposition. The ability to easily operate in multiple states is a unique benefit to the RRG.

### The Growth of Physician Owned Companies

Each time malpractice insurance premium price spikes occurred; physicians paid a little more attention to the factors that resulted in malpractice claims, and consequently, their higher premiums. Typically these approaches would include clinical reviews of risky cases and new approaches to customer service and communication following a bad outcome or event. But the attention was also focused on the malpractice insurance companies themselves and whether there might be a better way to provide medical malpractice coverage.

These seemingly endless cycles were not acceptable to physicians who felt that their premium costs ought to be based on whether or not they actually committed malpractice. This made it increasingly attractive to physician groups to disengage, to the extent possible, from the traditional insurance market.

The “disconnect” between premium price and actual malpractice made clear to physicians that their interests and the interests of the traditional insurance companies were not aligned. Physicians had regarded medical malpractice insurers as the “guy in

their corner” in the event of a lawsuit, but commercial insurers were beholden to their owners, who expected a return on their investment. Both parties behaved rationally, but their incentives were sometimes at cross-purposes. Because malpractice insurance had been viewed as a commodity and not a partnership, physicians felt victimized by what seemed to them as the capricious nature of the malpractice insurance market. The investments of an insurance company and the legal/tort environment in their community had more to do with their premium price than their competency as a physician.

### The Early Days of Physician-Owned Insurance

The physician-owned insurance of our contemporary time began in 1975 as a lightning-fast solution to an impending crisis. Bartholomew Nyhan, President and CEO of NCG Enterprises, relates his personal account of the early days. As a young insurance broker for Johnson and Higgins, he was sent out to California in 1970 with the objective of getting the medical societies to sponsor a new malpractice insurance product. At that time, sponsorship by the local medical society was still the method by which most physicians determined their insurance carrier of choice. At this time the unity and allegiance to the medical societies was strong and their endorsement or sponsorship of a program was paramount to the acceptance of the plan by the local medical community. By 1973 Northern California, with the exception of the Bay Area medical societies, was in this new insurance program through the traditional line company of Travelers Insurance. In 1975, however, Travelers Insurance not only issued an enormous increase in premium, but then gave 90 days notice that they would leave the medical malpractice

market. In Southern California, a similar scenario was underway with Pacific Indemnity. Rate increases throughout the state were 400% - 500%.

In New York State, the New York State Medical Society and its physician members were faced with a similar malpractice crisis due to the withdrawal of another traditional line insurer from their market. In response, the New York State Medical Society sponsored and launched a new mutual insurance enterprise, Medical Liability Mutual Insurance Company. Necessity dictated that California medical societies take these same steps to maintain some type of medical malpractice insurance for their members. The result was NORCAL Mutual Insurance Company in the in Northern California and Medical Insurance Exchange of California (MIEC) in Southern California. Licensed on November 1, 1975 and July 11, 1975, respectively, these fledgling companies stepped into the void to cover California physicians in the nick of time - with NORCAL enrolling 5,000 physicians on its first day. The ensuing several years saw a flurry of similar activity and the development of a dozen or so of these physician-owned mutual companies.<sup>16</sup>

Also particularly interesting about these new California companies was their use of Claims Made, rather than Occurrence based insurance. With the traditional Occurrence Policies, any claim was covered by the policy in force during the occurrence of the alleged malpractice. This potentially long delay in a claim being brought was problematic for actuaries in the forecasting of premiums and influenced companies like Travelers to withdraw from a market where they had most-likely under priced the premiums. These new physician-owned mutual companies employed a Claims Made

approach – now the industry standard – which means that a claim is covered by the policy in force at the time at which the claim is made. The Claims Made Policies provide a more accurate actuarial picture, and consequently, more accurate premium pricing.

The principals of these new companies quickly became collegial as a response to their shared interests and challenges. In 1977 these new companies formed the Physician Insurers Association of America, commonly known as the PIAA. The purpose of this organization, as stated on the PIAA's website, is for the exchange of information and problem solving. Early on, the PIAA was acutely aware of many of the same tort reform issues faced today. Supporting the passage of California's MICRA was an early galvanizing activity. Today, the PIAA Data Sharing Project, which details data from over 170,000 medical and dental claims, is a wealth of information to its members about risk management and claims administration.<sup>17</sup>

Over the years, the PIAA has grown significantly as evidenced by the growth in attendance from its first annual meeting of about fifty individuals to current annual meetings which exceed attendance by over a thousand industry professionals. In 1996 the Direct Written Premium of PIAA companies was Two Billion Dollars and 2005 finished with a total of Five Billion Dollars. Interestingly, the most dramatic increases in Direct Premiums occurred in 2001 and 2002 of 24.2% and 28.5% respectively – the beginning of the most recent hard market.<sup>18</sup>

#### Differences between investor-owned and physician-owned Malpractice Insurers

So how is it that the physician-owned companies are perceived as being able to solve at least some of the markets problems? The issues of tort reform are still largely unresolved as evidenced by the continuing attention in the public arena. However, the physician-owned companies seek to ameliorate the issue of incentives.

By creating an insurance company that is owned by the physician policy-holders, the incentives become aligned. The insurance company must be properly capitalized and managed to provide the product to the policy-holders, but a profit would inure to the benefit of the owners – those same policy holders. In this scenario, the focus becomes running the company for overall decrease of expenditures through the reduction of claims and losses, not a return to investors *per se*. The reduction in claims and loss expense returns to the owners through a rebate or lower premium, but there is no outside party to whom the company has a fiduciary duty or profit motivation.

Physician-owned companies operate similarly to investor-owned companies with some notable differences. Aside from simply a difference in ownership, the pricing relationship with policy holders is different. While physician-owned companies must have competitive premium pricing to attract new business, they do not have the same incentive to take advantage of “hard-markets” and price gouge. Since the customers and owners are one in the same, pricing reflects a conservative actuarial estimate of expense with the expectation that profits remain in the company or are returned to policy-holders.

Physician-owned companies also differ in governance to investor-owned companies.

Investor-owned companies are characterized by a corporate management and governance structure: a board elected by shareholders – not necessarily physicians and policy-holders, and a management team led by a CEO who creates a structure that he or she feels best runs the company.

Physician-owned companies are similar in that the Board is comprised of owners and selected insurance experts, but these owners are also the policy holders. The Board subcommittees (also comprised of policy-holders) are often a reflection of the focus of these physician-owned companies and include committees such as Claims Management, Patients Safety, and Finance.

#### Clinical and Risk Management

Most investor-owned companies have programs to reduce risk through a reduction in claims and loss expense, but many physicians find these token in nature. A large emergency group in Nevada was offered a 5% reduction in premium in 2003 from a traditional line insurer if all physicians completed an on-line risk course. The physicians each completed a course to obtain the discount, but none of the available topics were relevant to their specialty.

Many of the physician-owned companies are specialty specific which allows them to tailor relevant risk management education to their policy holders based on their own claims history. That same emergency physician group is now insured by and is an owner

of a physician-owned company has completed on-line continuing medical education for a premium discount, but this time the clinical topic chosen is relevant to their specialty. The particular topic of education was selected to address high risks identified from actual claims data experienced within the physician-owned company. The physicians are typically highly motivated to participate in this education for a number of reasons beyond the obvious benefit to the patients they care for. First, the anxiety experienced during a lawsuit is something all physicians want to avoid. Second, a premium discount creates an immediate financial incentive. And third, reduction of risk and claims throughout the company results in an advantageous financial situation for the company – which is returned to the owners via premium reduction or rebate.

While there are many such contemporary examples, one of earliest examples of the insurance/risk reduction models occurred in the mid-1980s at Harvard. The nine teaching hospitals at Harvard, all of whom were self insured by its own medical malpractice insurance company, undertook to evaluate the standards in anesthesia monitoring as a direct result of the catastrophic outcomes and resulting large malpractice settlements. The study, published in the Journal of the American Medical Association made it clear that the impetus for this study and resultant standards rose from the risk management committee of their own insurance company. The recommended monitoring which was implemented at Harvard, and became the standard of care throughout the country, cost an additional \$5 per case at a time when the cost of malpractice insurance per case was \$53.19

The reason that this Harvard study is so relevant in the historical perspective of physician-owned (in this case facility-owned) insurance is that it was the first major published study in which the policy holders and practitioners, which were one in the same, demonstrated improved patient safety based on their own risk management data. Contrast this with the investor-owned insurance model where there is no incentive to improve care and reduce claims – simply raise the premium. Also, consider that if Harvard had made these changes while insured by an investor-owned carrier, their rates most likely would not have gone down as significantly because their pricing would have been the result of their pricing for their whole region of similar facilities.

### Claims Management

The history of malpractice litigation has many unfortunate examples of physicians who felt at cross purposes with their insurance company during the claims management and litigation process. Again, remember that the investor-owned company has a duty to its shareholders to generate a profit, not necessarily defend the physician to the extent he or she may desire. When faced with a case that would cost more to defend than settle, the idea of whether or not malpractice actually occurred is not necessarily at the forefront.

Virtually all medical malpractice policies contain language that requires the physician to consent to a settlement by the insurer on the physician's behalf. This differs from most other lines of insurance where the policy-holder has no say in what is paid. For instance,

after a car collision, the insurance agency does not call the policy holder of the car insurance to determine if they would be amenable to a particular settlement. A significant factor which accounts for this difference is the National Practitioner Data Bank (NPDB). The Health Care Quality Improvement Act of 1986 established a national repository that would be the clearinghouse for any information about a physician who has made malpractice payments, been the subject of sanctions taken of Boards of Medical Examiners or certain professional review actions taken by health care entities. With regard to malpractice payments, reporting is required by “each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report, in accordance with section 424, information respecting the payment and circumstances thereof.”<sup>20</sup>

While the NPDB was, and continues to be, a good mechanism to track practitioners with a bad malpractice history that might simply relocate, the NPDB changed how physicians felt about their insurer settling claims that are perceived by the physician and/or insurer as frivolous. Now, that frivolous claim that the insurer might like to settle for financial expediency would be reported to every hospital and potential insurer and employer for the rest of the physician’s career. One can hardly blame a financially motivated insurance company for considering early settlement of frivolous cases when in 2002 the U.S. Department of Health and Human Services reported that it costs an average of \$24,669 to defend a claim – even though the vast majority of claims never go to trial.<sup>21</sup>

To protect physicians from the threat to his or her reputation from an adverse Data Bank report, a physician's consent is required to settle a case. This is a simple solution at first review, but more complicated in practicality. Each medical malpractice policy defines its policy limits of insurance. In most communities, \$1,000,000 per occurrence (or case) and \$3,000,000 per year is a typical limit per physician. If the physician consents to settlement within his or her policy limits, the physician may have to explain the case from the rest of their career if the insurer settles. If, however, the physician does not consent, the physician is personally responsible for any judgment that might exceed the limits of the physician's policy. Most physicians would rather explain a clinically frivolous case to their hospital and peers than risk putting a case in front of a jury where they might be at risk for personal assets. Thus, the concept of physician consent has become more of a legal maneuver than a statement on the behalf of a physician about his or her true regard for the merit of the claim.

In many instances, the investor-owned insurer would want to defend a clinically strong case to save the insurance company from a large unwarranted payment. In the cases in which the defense costs exceed the potential claim, however, the incentives again fall out of alignment. Companies run by physicians for their benefit are perceived to be more sensitive to defending a physician in a frivolous case even if it would be financially advantageous to settle.

### Conclusion

A look at history explains how medical malpractice insurance has become so intrinsic to our modern delivery of health care. History also demonstrates how the rise of physician-owned medical malpractice is a rational market response, but history fails to resolve the festering issues that relate the adjudication of medical malpractice cases in the United States. Defense costs in medical malpractice cases continue to increase as the stakes rise as a result of jury verdicts of increasing size. While tort reform has become effective in some states, the absence of national reform renders these gains spotty at best.

Many would argue that medical malpractice litigation is characterized by some of the most complex technical issues found at trial. Medical malpractice cases (in contrast to bankruptcy and family law) are still adjudicated by a jury of the plaintiff's peers, not by trained medical professionals or even judges who specialize in medical malpractice. The lay jury is subjected to dueling expert opinions, and they are ill-equipped to evaluate the merits and shortcomings of the arguments. In such a setting, it seems unlikely that sanity will return to the legal proceedings that are increasingly driving the premium expense of medical malpractice insurance. The public policy arena continues to grapple with these issues.

Ironically, the rise of physician-owned medical malpractice represents a return, at least in philosophy, to the beginnings of medical malpractice insurance which was originally sponsored by medical societies. The physician-owned companies give physicians a comforting and desired sense of control over a situation that has not historically manifested itself as rational to physicians.

In the long-run, investor-owned companies react to the market and profit incentive – right or wrong. Any type of insurance is, at the end of the day, a purchase of the right to transfer risk from one’s self to another entity. Any right-minded investor would only purchase another’s risk for a profit. Given the reality of these market forces, it seems likely that the role of physician-owned medical malpractice – the market’s response - will continue to rise in its prominence.

---

## ENDNOTES

1 Rick Mortimer, Jr. “The Malpractice Hard Market is Over – For Most.” MGMA Connexion January 2006

2 Starr, Paul. The Social Transformation of American Medicine. Harper Collins Publishers, 1982., pg. 17

3 [www.piaa.org](http://www.piaa.org)

4 Spiegel, Allen D. Ph.D., MPH and Kavalier, Florence, M.D., M.P.H. “America’s First Medical Malpractice Crisis, 1835-1865” Journal of Community Health Vol. 22, No.4, August 1997

---

5 Webster J. “Introductory to the Course on Anatomy in Geneva Medical College”,  
March 7, 1950. *Geneva: Volenburgh*, 1850, pp. 6, 12.

6 Stephens, Everett M.D., Medical-Legal Liability in Emergency Medicine, eMedicine,  
August 8, 2005 [www.emedicine.com/emerg/topic945.htm](http://www.emedicine.com/emerg/topic945.htm)

7 Starr, pg. 111

8 Lewis, Bonne, CPMSM, Director of Medical Staff Services, Saint Mary’s Regional  
Medical Center, Reno, Nevada

9 U.S. Department of Health, Education and Welfare, Report of the Secretary’s  
Commission on Medical Malpractice (Pub. No. (OS) 73-88, Washington, D.C.:  
DHEW, 1973a).

10 California’s Medical Injury Compensation Reform Act of 1975 ”MICRA.”  
*Californians Allied for Patient Protection.*  
[www.micra.org/MICRAprovisions.pdf](http://www.micra.org/MICRAprovisions.pdf)

11 “Professional Liability in the ‘80’s, Report 1” *American Medical Association.*  
(Chicago: AMA, October, 1984a).

12 Milt Freudenheim. “St. Paul Cos. Exits Medical Malpractice Insurance.” The New  
York Times December 13, 2001.

---

13 “America’s Medical Liability Crisis” *American Medical Association*, February 2005.

14 Frank, Ted, “Malpractice Myths” PointofLaw.com: Information and opinion on the U.S. litigation system. February 23, 2005.  
[www.pointoflaw.com/columns/archives/000975.php](http://www.pointoflaw.com/columns/archives/000975.php)

15 “Medical Professional Liability Insurance” American College of Emergency Physicians [www.acep.org](http://www.acep.org).

16 Nyhan, Bartholomew, MBA, CLU

17 “History” Physician Insurers Association of America.  
[http://www.piaa.us/about\\_piaa/history.htm](http://www.piaa.us/about_piaa/history.htm)

18 Hurley, Jim “Medical Malpractice – Financial Update” Towers Perrin 2005

19 Eichhorn, John H., M.D., Cooper, Jeffrey B., Ph.D., Cullen, David J., M.D., Maer, Ward R., M.D., Philip, James H., M.D., Seeman, Robert G., M.D. “Standards for Patient Monitoring During Anesthesia at Harvard Medical School.” Journal of the American Medical Association August 22/2, 1989- Vol 256, No. 8

20 Title IV – Health Care Quality Improvement Act of 1986, P.L. 99-660, Approved November 14, 1986 (100 Stat. 3743)

21 Aloy, Karen M., CPA, FACMPE. “Is Captive Insurance a Viable Option for Rising Malpractice Premiums?” *MGMA Article Archive: ACMPE Paper*, August 2004.

---

## **Bibliography**

### **BOOKS**

Starr, Paul. The Social Transformation of American Medicine. Harper Collins Publishers, 1982.

### **DIRECTORIES**

“2004-2005 Membership Directory & Professional Services Section” Physician Insurers Association of America. 2005

### **FACTSHEETS**

“Addressing the Medical Malpractice Insurance Crisis” *NGA Center for Best Practices*, December 5, 2002.

“America’s Medical Liability Crisis” *American Medical Association*, February 2005

“California’s Medical Injury Compensation Reform Act of 1975 “MICRA”” *Californians Allied for Patient Protection: The Coalition to Protect MIRCRA*.

“Medical Liability Crisis Fact Sheet.” *American College of Emergency Physicians*. [www.acep.org](http://www.acep.org)

“PIAA Public Statement on July 11, 2005 Angoff Paper: “Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry.”” *Physician Insurers Association of America*.

### **INTERVIEWS**

Billingham, Graham, M.D., Chief Executive Officer, Emergency Physician Insurance Company, Inc., February 15, 2006.

Lewis, Bonne, CPMSM, Director of Medical Staff Services, Saint Mary’s Regional Medical Center, Reno, Nevada, June 5, 2006

Nyhan, Bartholomew, MBA, CLU, Founder, President and CEO of NCG Enterprises, LLC and NCG Insurance Managers, LLC, August 10, 2006.

### **JOURNAL ARTICLES**

Aloy, Karen M., CPA, FACMPE. “Is Captive Insurance a Viable Option for Risking Malpractice Premiums?” *MGMA Article Archive*, August 2004.

Eichhorn, John H., M.D. “Prevention of Intraoperative Anesthesia Accidents and Related Severe Injury through Safety Monitoring.” *Anesthesiology* 70: 572-577, 1989

Eichhorn, John H., M.D., Cooper, Jeffrey B., Ph.D., Cullen, David J., M.D., Maier, Ward R., M.D., Philip, James H., M.D., Seeman, Robert G. M.D. “Standards for Patient Monitoring During Anesthesia at Harvard Medical School.” *Journal of the American Medical Association*, August 22/29, 1986.

---

Frank, Ted. "Malpractice Myths." *PointofLaw.com* February 23, 2005.

Mortimer, Richard. "The Malpractice Hard Market is Over – For Most." *MGMA Connexion*, Vol.6, Issue 1, January 2006

Rice, Matthew M., MD, JD, FACEP, "Medical Professional Liability Insurance" *American College of Emergency Physicians*, Medical Leal Committee. April 2004.

Rosenfeld, Erika, "Medical Malpractice: Wants, Needs, Opposing Views" *Insurance Advocate*. March 28, 2005.

Scott, Shena J., MBA, FACMPE. "The Medical Liability Insurance Crisis of 2003: History Repeating Itself or a New Frontier?" *MGMA Article Archive*, August 2003.

Scott, Shena J.. "Duck and Cover." *MGMA Connexion*, July 2004.

Spiegel, Allen D., Ph.D., Kavalier, Florence, M.D., M.P.H. "America's First Medical Malpractice Crisis, 1835-1865." *Journal of Community Health*, Vol. 22, No. 4, August 1997.

### **LEGISLATION and FEDERAL PUBLICATIONS**

National Practitioner Data Bank: 2004 Annual Report. U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Professions Practitioner Data Banks Branch.

Title IV – Health Care Quality Improvement Act of 1986. P.L. 99-660, Approved November 14, 1986 (100 Stat.3743)

Update on the Medical Litigation Crisis: Note the Result of the "Insurance Cycle." U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, September 25, 2002.

### **WEBSITES**

"Professional Liability Insurance: A Brief History" *MLMIC Services*.  
<http://www.mimic.com/history.htm>.

"Malpractice Premiums Soar" *Insure.com*.  
<http://info.insure.com/health/medliability201.html>

"Medical-Legal Liability In Emergency Medicine." *eMedicine*. August 8, 2005.  
<http://www.emedicine.com/emerg/topic945.htm>

"Medical Malpractice." [www.wikipedia.org/wiki/Medical\\_malpractice](http://www.wikipedia.org/wiki/Medical_malpractice)

"Strike Three for CJD on Medical Malpractice: Latest Study Adds to List of Unsupportable Conclusions on Medical Malpractice." *Physician Insurers Association of America*, March 17, 2006.  
[www.thepiaa.org/press\\_releases/2006](http://www.thepiaa.org/press_releases/2006)

"About PIAA" *Physician Insurers Association of America*. August 23, 2006 [www.thepiaa.org](http://www.thepiaa.org)

