

IN THE SUPREME COURT OF OHIO

Mark A. McLeod, Guardian of the Estate of Walter Hollins, Appellee, v. Mt. Sinai Medical Center, and Ronald Jordan, M.D. and Northeast Ohio Neighborhood Health Services, Inc. f/k/a Hough-Norwood, Appellants. : Case No. 06-1247 : On Appeal from the Cuyahoga County Court of Appeals, Eighth Appellate District : Court of Appeals : Case Nos. 04-85286, 04-85574, & 04-85605 (Consolidated)

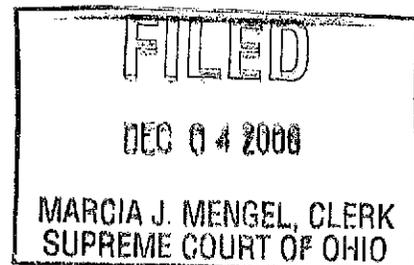
**BRIEF OF AMICI CURIAE,
THE OHIO HOSPITAL ASSOCIATION,
THE OHIO STATE MEDICAL ASSOCIATION, AND
THE AMERICAN MEDICAL ASSOCIATION
IN SUPPORT OF APPELLANTS**

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STATEMENT OF FACTS

Amici curiae, the Ohio Hospital Association (“OHA”), the Ohio State Medical Association (“OSMA”), and the American Medical Association (“AMA”), incorporate the Statement of Facts submitted by Appellants in this case.

INTEREST OF AMICI CURIAE

This case is of utmost importance to the medical community. It involves the fundamental right afforded by the Ohio Constitution to a *fair* jury trial in the context of a medical negligence action. It also involves a \$30 million judgment which:

- according to the trial judge, was tainted by improper conduct of counsel and erroneously admitted evidence, and was influenced by the passion and prejudice of the jury, and
- according to the court of appeals, was “manifestly excessive.”

Ohio’s medical community and the millions of Ohioans that it serves cannot withstand tainted verdicts, especially ones of this magnitude, without ramifications to the health care system at large. The risk of tainted judgments, let alone excessive ones, being upheld against medical providers will undoubtedly have a negative impact on Ohio’s medical liability insurance market and, ultimately, on Ohio’s patient population as patients find it more difficult to obtain access to needed medical services.

Earlier this decade, “the Ohio liability insurance market began to slip into what we now recognize as a crisis.”¹ In response, the General Assembly enacted S.B. 281 to address concerns that Ohio medical liability insurance had become unaffordable and, thus, was impacting Ohio’s patient population due to physicians leaving the state, retiring early, or ceasing to perform high risk procedures. A report prepared by the Ohio Department of Insurance in 2004, confirmed that

¹ Final Report and Recommendations of the Ohio Medical Malpractice Commission, April 2005, at 3 (“Ohio Medical Malpractice Commission’s Final Report”), attached hereto as Exhibit A (but without all of the exhibits).

“high medical liability premiums are having an effect on health care services in Ohio, and that Ohio could soon face a crisis of access to care.”² “While the Ohio medical liability market is beginning to recover, it is still in a state of crisis.”³ And, “the primary driver of medical malpractice rates is the costs associated with losses and defense of claims.”⁴ It is against this backdrop that *amici curiae* urge the Court to establish a rule of law to protect medical providers from tainted and/or excessive verdicts.

The OHA is a private nonprofit trade association established in 1915 as the first state-level hospital association in the United States. From its first major legislative undertaking involving the federal Harrison Narcotic Act, the OHA has provided a mechanism for Ohio's hospitals to come together and develop health care legislation and policy in the best interest of hospitals and their communities. The OHA is comprised of more than one hundred seventy (170) private, state and federal government hospitals and more than forty (40) health systems, all located within the state of Ohio; these hospitals and health systems employ more than 240,000 employees. The total number of people working in Ohio hospitals, including physicians and volunteers is 303,000. The OHA's mission is to be a membership-driven organization that provides proactive leadership to create an environment in which Ohio hospitals are successful in serving their communities.

The OSMA is a non-profit professional association founded in 1835 and is comprised of approximately 16,000 physicians, medical residents, and medical students in the State of Ohio. The OSMA's membership includes most Ohio physicians engaged in the private practice of medicine, in all specialties. The OSMA strives to improve public health through education, to

² *Id.* at 5.

³ *Id.* at 6.

⁴ *Id.* at 7.

encourage interchange of ideas among members, and to maintain and advance the standards of practice by requiring members to adhere to the concepts of professional ethics.

The AMA, an Illinois nonprofit corporation, is the largest professional association of physicians, residents and medical students in the United States. It has approximately 240,000 members who practice in every state and in every medical specialty. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health.⁵

ARGUMENT

While all of the propositions of law upon which this Court has accepted review in this case are important to *amici curiae*, the focus of this brief is Proposition of Law No. III set forth below.

PROPOSITION OF LAW NO. III:

When the jury renders an excessive verdict after hearing surprise testimony suggesting damages exceeding those supported by plaintiff's expert reports, and after a trial and closing argument pervaded by attacks on the defendants and appeals to religion, race, and economics, a trial judge does not abuse his discretion by concluding that the verdict is influenced by passion and prejudice requiring a new trial rather than *remittitur*.

This case addresses the fundamental right afforded by the Ohio Constitution to a fair jury trial in the context of a medical negligence case. Ohio Constitution, Article I, §5. The right to a fair jury trial is guaranteed to all litigants, not just for their benefit but also for the benefit of all Ohio citizens. Perhaps nowhere does the impact of this right extend beyond the litigants to the public at large more than in medical negligence cases. This is particularly true given the complex medical issues involved in medical negligence cases and the fragile nature of Ohio's

⁵ The AMA and the OSMA are participating in this brief in their own persons and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies ("Litigation Center"). The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, non-profit state medical societies to represent the views of organized medicine in the courts.

health care system, which continues to struggle to overcome a medical liability insurance crisis while striving to make quality, affordable health care available to all Ohio citizens.

For these reasons and the reasons set forth below, *amici curiae* urge this Court to reinstate the well reasoned decision of the Trial Court granting the defense a new trial so that the dispute at issue in this case can be heard and decided by a jury based upon the merits, thereby affording the litigants to this case and all Ohio citizens the opportunity for the fair trial that they deserve.

A. It Is Impossible To Get A Fair Jury Trial Where The Evidence⁶ Presented To The Jury Is Obscured And/Or Manipulated.

As this Court is well-aware, an essential component for a fair jury trial is the existence of a panel of eight Ohio citizens who are each able and willing to make a fair and impartial decision based upon the evidence presented to them. See Civ.R. 38(B). However, even the best intentioned jury panel cannot provide a fair jury trial where the evidence presented to them for consideration is obscured and manipulated beyond recognition. This is true of the evidence in any case, but is critical in medical negligence cases where the evidence is already extremely difficult for a lay jury to understand and process. Because a jury is obligated to consider the evidence it is given, distorting and misrepresenting that evidence irreparably taints the entire process and dispels any hope of fairness or justice.

- 1. Any attempt by counsel to misrepresent medical testimony to a jury must be prohibited because it eliminates the possibility of a fair trial.**

In a medical negligence action, the jury is generally asked to decide whether the plaintiff

⁶ Because the inappropriate conduct of Plaintiff's counsel affected the evidence that was presented to the jury, the term "evidence" is used broadly throughout this brief to include both the evidence itself and the conduct of Plaintiff's counsel.

can satisfy three separate, but interrelated elements.⁷ See *Bruni v. Tatsumi* (1976), 46 Ohio St.2d 127, 131, 346 N.E.2d 673, 677. It must first decide whether each defendant provided care that was inconsistent with the appropriate standard of care for his or her medical specialty. *Id.* See also *Littleton v. Good Samaritan Hospital and Health Center* (1988), 39 Ohio St.3d. 86, 92, 529 N.E.2d 449, 454; *Cooper v. Sisters of Charity of Cincinnati* (1971), 27 Ohio St.2d 242, 250, 272 N.E.2d 97, 102. If the jury decides that the care provided by any defendant was below the appropriate standard for that provider's specialty, the jury must next decide whether the below standard care that it identified was the direct and proximate cause of harm to the plaintiff. *Bruni*, 46 Ohio St.2d 127, 131. If the answer to that question is yes, the jury must decide the nature and extent of damage caused, and the appropriate monetary value that should be assigned for that injury.

In order to consider and reach a determination with respect to each of these elements, the jury is provided with evidence in the form of medical records, testimony of fact witnesses, testimony of expert witnesses, etc. While some of the evidence presented will deal with only one of the elements for determination by the jury, other evidence will deal with two or even all three elements.

Much of the evidence presented in a medical negligence case, particularly with respect to issues of liability, is expert medical testimony. Specifically, before a jury can determine whether a defendant is liable to the plaintiff, it needs to consider both evidence addressing the appropriate standard of care that applies to that defendant in his or her area of medical specialty and evidence addressing the way that the available medical care can or cannot impact a patient's outcome.

⁷ The term generally is used to reflect the fact that medical negligence cases can proceed with a stipulation as to some of the elements, leaving the jury to determine only the remaining elements. In the case at bar, the jury was asked to determine all three elements as there were no stipulations on any of the elements of the claim.

These are incredibly complex concepts that are presented through physicians who have spent many years gaining their knowledge, but only have a few hours to teach these concepts to a lay jury. Undoubtedly, we expect a great deal from a jury – they must digest the evidence sufficiently to apply it to the facts of the case and use it to judge the actions of the named medical providers. Add to this task the fact that there is almost always disagreement between and among the experts retained by the respective parties and it is clear that this most critical evidence is highly susceptible to confusion.

Although not witnesses themselves, the trial attorneys spend more time speaking in front of the jury than anyone else during the course of a trial. This provides them with several opportunities to interject their personal opinions or interpretations regarding the evidence. These opportunities are present during voir dire, opening statements and closing arguments, as well as during direct and cross-examinations. At each of these opportunities, some “poetic license” may be appropriate where the respective parties reach different conclusions based upon the same evidence or genuinely recall the evidence differently. Conversely, intentional misrepresentation of the evidence is *never* appropriate. See *Fehrenbach v. O’Malley* (2005) 164 Ohio App.3d 80, 91, 841 N.E.2d 350, at ¶ 23 (citing *Pesek v. Univ. Neurologists Assn., Inc.* (2000), 87 Ohio St.3d 495, 721 N.E.2d 1011). In fact, as already recognized by this Court, “[t]he proper role of an attorney at the trial table is not that of a contestant seeking to prevail at any cost but that of an officer of the court, whose duty is to aid in the administration of justice and assist in surrounding the trial with an air conducive to an impartial judgment.” *Jones v. Macedonia-Northfield Banking Co.* (1937), 132 Ohio St. 341, 349-350, 7 N.E.2d 544, 548.

In the case at bar, numerous medical expert witnesses were called representing a variety of medical specialties by each of the parties. See *McLeod v. Mt. Sinai Medical Ctr.* (2006), 166

Ohio App. 3d 647, 663, 853 N.E.2d 1235, 1247 (Karpinski, J., dissenting). These included an expert in pediatric neurology and a maternal-fetal medicine expert. *Id.* The position presented through the Plaintiff's experts was that the various Defendants fell below the standard of care in their medical specialties and their failures were the proximate cause of his injuries. *Id.* Conversely, the position presented through the Defendants' experts was that the care provided was appropriate and in conformance with the applicable standard of care and did not proximately cause Plaintiff's injuries. *Id.* Throughout the presentation of all of this evidence on the two issues that comprise the "liability" determination, Plaintiff's counsel relentlessly misrepresented key aspects of the medical evidence, often defying judicial admonishments in the process. *Id.* at 666. As explained by Judge Karpinski in the dissenting opinion, examples of this flagrant misrepresentation included the repeated and intentional misuse of the term "fetal distress" to equate to imminent death from asphyxia and the misuse of the term "emergency c-section" to equate to a crisis requiring immediate action rather than simply an unscheduled c-section. *Id.*

These mischaracterizations were inconsistent with the meanings that were consistently attributed to those terms by all of the medical providers using them while providing care to the Plaintiff. *Id.* For a jury struggling to understand a deceleration on a fetal monitor strip (let alone whether it is good, bad or somewhere in between), counsel's assigning improper meaning and significance to medical terms makes the jury's role to fairly consider the evidence impossible. By misrepresenting the evidence addressing liability, Plaintiff's counsel tainted the evidence relating to the issues of liability and denied the parties, and the public, a fair jury trial in this case. See *Maggio v. Cleveland* (1949), 151 Ohio St. 136, 84 N.E.2d 912, paragraph two of the syllabus; see also *Drake v. Caterpillar Tractor Co.* (1984), 15 Ohio St.3d 346, 350, 474 N.E.2d 291, 293 (applying the holding in *Maggio* to closing arguments). This must be rectified.

B. Where Tainted Evidence Addressing Liability Has Been Presented To A Jury, The Only Available Remedy Is To Order A New Trial

Where evidence presented to a jury is tainted, the decision made by the jury based on such evidence is also tainted. In that instance, it is incumbent upon the court to provide a remedy because neither party received the fair trial guaranteed by the Ohio Constitution. See *Manigault v. Ford Motor Company* (2002), 96 Ohio St.3d 431, 433, 775 N.E.2d 824, 826 (holding that a new trial was the appropriate remedy, because defense counsel presented evidence that was “seriously misleading”). In order to identify the most appropriate remedy in a medical negligence case where the issue is tainted evidence, the court must determine which elements the evidence addressed. Where the tainted evidence only addressed the element of damages, remittitur may be appropriate. See *Brooks v. Wilson* (1994), 98 Ohio App.3d 301, 307, 648 N.E.2d 552, 556. Conversely, where the tainted evidence addressed the elements of standard of care, proximate causation, or both, the only appropriate remedy is a new trial. See *id.* See also *Manigault v. Ford Motor Company*, 96 Ohio St.3d 431, 433.

1. Remittitur is an incomplete and inadequate remedy where the evidentiary error relates to liability.

Remittitur is one remedy available to trial courts where tainted evidence was produced during trial. This remedy is designed to correct an unfair judgment where the court’s only concern is the *amount* of the verdict awarded by the jury. Because remittitur does not disturb the liability determination, it is necessarily premised upon the conviction of the Court that the evidence that addressed both standard of care and causation was *not* tainted. Therefore, this remedy is only appropriate where the tainted evidence related exclusively to the element of damages and valuation. Because the case before this Court involved tainted evidence addressing both standard of care and proximate causation, remittitur is not an appropriate remedy.

Prior to the trial herein, the Plaintiff submitted reports estimating the cost that would have to be incurred to provide his care for the balance of his lifetime. The reports reflected care by a home health care aide, not a registered nurse or other medical professional, and stated an estimated value between \$4,303,088 and \$6,413,639. Accepting these figures, the defendants did not retain an expert of their own to refute the estimated cost of care. Although there was absolutely no evidence supporting the need for any registered nursing care and no mention of registered nursing care in the reports submitted prior to trial, the Plaintiff presented evidence at trial that if the same level of care were provided by a registered nurse, it would cost three times as much as previously reported for an aide. *McLeod*, 166 Ohio App. 3d. 647, 663 (Karpinski, J., dissenting). Permitting the Plaintiff to present this evidence to the jury, both through the economist and through a medical expert witness, was improper and denied the parties a fair trial because it artificially inflated the value of Plaintiff's claim.⁸ If this were the only improper evidence, remittitur may provide an appropriate remedy. But, here, the improper evidence permeated throughout the trial and affected everything, including the elements required to establish liability. Therefore, remittitur here would provide an incomplete and inadequate remedy.

2. A new trial is the only appropriate remedy where the evidentiary error relates to liability.

A new trial is another remedy available to trial courts where tainted evidence was produced during trial. This remedy is designed as a "do over" when a fair trial was not afforded on the first attempt. Unlike remittitur, which cannot correct errors addressing issues of liability, a new trial does provide a means of correcting errors where evidence presented to a jury that addressed either standard of care or causation was tainted. Because the case before this Court

⁸ *McLeod*, 166 Ohio App. 3d. 647, 663 (Karpinski, J., dissenting).

involved tainted evidence addressing issues of both standard of care and proximate causation⁹, a new trial is the only appropriate remedy.

The record is replete with examples of misrepresentations of the evidence by Plaintiff's attorney during the trial. As referenced above, this includes repeated attempts with multiple witnesses to misrepresent the meaning and significance of key medical terminology used by the medical providers. This conduct rendered the well meaning jury utterly incapable of reaching a fair decision on the merits relative to the liability determination. Specifically, liability is an all or nothing proposition based upon the Plaintiff's ability to establish a deviation from the standard of care and proximate causation to a preponderance of the evidence. There is simply no way for the trial court to remove the tainted evidence from the scales of justice to see if they no longer tip in favor of liability. Only by presenting untainted evidence to a jury for consideration can a fair determination be made. This requires a new trial.

C. The Impact Of Unfair Jury Trials In Medical Negligence Actions Reaches Far Beyond The Litigants

Anytime justice is not served because parties to litigation are denied a fair jury trial, Ohio citizens are injured. While the parties to the litigation are the most immediately and directly affected, nonparties to the litigation are not spared. Not only do they experience a loss of faith in the system of justice, but in the context of medical negligence cases, nonlitigants also face the risk of loss of medical services caused by the impact of the tainted judgment(s) on the individual provider(s) or the health care system generally. Although every single tainted verdict will not necessarily have a noticeable impact beyond the litigants, a tainted verdict that is excessive -- or the cumulative result of multiple tainted verdicts -- will likely harm the medical liability insurance market, self-insured hospitals, and Ohio's patient population.

⁹ *Id* at 665-666 (Karpinski, J., dissenting).

It is no secret that Ohio has been facing a crisis in the area of medical liability insurance. See Ohio Commission's Final Report. Since 2000, nine medical liability carriers left the Ohio insurance market. *Id.* at 4. Health care providers, such as doctors and hospitals, faced significant increases in premiums. *Id.* News stories throughout Ohio featured doctors who were closing their doors or limiting their practices because they were unable to obtain affordable insurance coverage. During this same time, numerous hospitals closed maternity wards and eliminated other patient services. Many closed their doors entirely. In fact, over the course of the past decade, at least thirty-two (32) different hospitals have closed in Ohio due, in large part, to the financial strains placed upon those institutions as a result of increased insurance costs.¹⁰

¹⁰ The OHA maintains an updated list of hospital closures in Ohio from 1980 to the present. Many of the closures are clearly attributable to financial losses. From 1994 through 2003, approximately 32 different hospitals were closed, compared with only 22 during the prior fourteen-year period. The affected hospitals include: **2003:** UHHS Saint Michael Hospital; Deaconess Hospital. **2002:** Riverside Mercy Hospital. **2001:** River Valley Health System (two hospitals); Doctors Hospital North; Columbus Community Hospital; Mercy Hospital Hamilton. **2000:** Bethesda Oak Hospital; Mt. Sinai Medical Center-University Circle; Youngstown Osteopathic Hospital; Veterans Memorial Hospital; Richland Hospital; Franciscan Medical Center; Oak Hill Community Medical Center. **1999:** Saint Luke's Medical Center; MedCenter Hospital. **1998:** Jewish Hospital (2 campuses consolidated into one location); Peoples Hospital; Dettmer Hospital; Stouder Memorial Hospital; and Piqua Memorial Medical Center (services consolidated at the new Upper Valley Medical Center, so net loss of just two hospitals, not three). **1996:** Fallsview Psychiatric Center; St. Joseph Riverside; Warren General Hospital; Western Reserve System – Southside; Care Unit Hospital; Woodside Hospital; Dartmouth Hospital; Mercy Hospital. **1995:** Molly Stark Hospital. **1994:** Emerson A. North Hospital; Parkview Hospital; Potters Medical Center; St. Joseph Hospital and Health Center; Brentwood Hospital. **1993:** Kettering-Mohican Area Medical Center. **1991:** MetroHealth Hospital for Women. **1990:** St. John Hospital of Cleveland. **1989:** Wellington Community Hospital. **1988:** Central Ohio Adolescent Center; Northeastern Ohio General Hospital. **1987:** Southern Hills Hospital. **1986:** Kaiser Foundation of Cleveland; Wayne General & Podiatry. **1985:** Rickly Memorial – Ohio Masonic Home; Woodland Centers; University of Cincinnati/Christian R. Homes Division. **1984:** Shaker Medical Center Hospital; Women's Hospital. **1983:** New London Hospital; New Horizon Center Hospital; Frazier Health Center. **1982:** Dayton Children's Psychiatric Hospital; Fairhill Mental Health Center. **1981:** Bay View Hospital; St. George Hospital. **1980:** Gibbons Hospital.

The trend continues today. (In fact, Mt. Sinai Hospital in Cleveland, Ohio, one of the defendants in this case, has recently closed its doors.)

Over the period from 2001 through 2005, Ohio's five largest medical malpractice insurers, which cumulatively write about two-thirds of the Ohio market, experienced an aggregate increase in physician and surgeon malpractice insurance rates of 194.7%. *Id.* While there have been some recent signs that Ohio's medical liability insurance market is beginning to stabilize¹¹, medical malpractice insurance rates in Ohio are still extremely high overall, and particularly in certain geographic areas and medical specialties. For instance, in 2005, a neurological surgeon practicing in Ashtabula, Geauga, Lake, Mahoning, Portage or Trumbull Counties could expect to pay \$227,599 for a fully mature claims made policy with limits of \$1 million per claim and \$3 million aggregate ("\$1M/\$3M," amounts which represent typical policy limits). See Ohio Department of Insurance Table, "Ohio Physicians Surgeons Medical Malpractice Rates: Selected Specialties by County," "Neurological Surgery," attached hereto as Exhibit C. A neurological surgeon practicing in Cuyahoga or Lorain Counties might expect to pay \$252,888 for that policy. An OB/GYN practicing in those counties could expect to pay \$190,407 to \$211,563 in 2005 for a \$1M/\$3M policy. See Ohio Department of Insurance Table, "Ohio Physicians Surgeons Medical Malpractice Rates: Selected Specialties by County," "OB/GYN," attached hereto as Exhibit D.

Even as Ohio malpractice insurance rates increased dramatically, the total costs for medical malpractice claims (including costs for payments to claimants and costs for investigation and defense of claims) exceeded medical malpractice premiums. Over a three-year period,

¹¹ Shannon Mortland, *Docs Find Relief at Last; Tort Reform Helps Apply Brakes to Steep Malpractice Insurance Hikes; More Physicians Staying in Ohio*, CRAIN'S CLEVELAND BUSINESS, Sept. 11, 2006, attached hereto as Exhibit B.

encompassing 2001 through 2003, for every \$1.00 of premium received, Ohio's five largest medical malpractice insurers paid out \$1.23 for claims. See Ohio Department of Insurance Table, "Premium, Losses, and Cost of Investigation and Defense," attached hereto as Exhibit E (showing the ratio of total claims costs to premiums experienced by Ohio's five largest medical malpractice insurance carriers was 123.7%).¹²

This documented increase in medical malpractice costs has had a substantial impact on physicians in Ohio, according to a recent survey conducted by the ODI. See Ohio Department of Insurance Report, "Physician Medical Malpractice Insurance Survey," attached hereto as Exhibit F. The survey found that nearly forty percent of respondents had retired or planned to retire in the next three years because of rising insurance costs. *Id.* (Only nine percent of respondents were over age sixty-four.) *Id.* In particular, physicians in high-risk fields such as neurology and specialty surgery, associated with the highest rates of malpractice insurance, were especially likely to retire. *Id.* Increases in medical malpractice insurance rates affect patient care in other ways as well. Sixty-six percent of the physicians who responded to the ODI survey reported that they have turned down high-risk patients or referred high-risk procedure patients elsewhere. *Id.* The results of the ODI survey indicate that this Court's decision as to whether a plaintiff may enjoy the overcompensation received as a result of an unfair trial will have far-reaching effects.

This Court's decision will also have a significant impact on self-insured entities in Ohio. As many as 50% of Ohio hospitals are self-insured for liability risks. When self-insured hospitals are required to increase their reserves for claims (as they would be to account for the increased risk emanating from the appellate court's decision), they must reallocate resources. This often means cutting other programs and services offered to patients, employees, and the

¹² This information was compiled by the National Association of Insurance Commissioners and is believed to be the most recent data available for this information.

community at large. It is not possible for the health care industry to fund the overcompensation of plaintiffs at the same time that it pursues other goals such as caring for the uninsured¹³ and furthering medical research, especially since this overcompensation occurs in the context of a system with limited resources.

The health care system in Ohio is in a vulnerable state. As a result of an ongoing malpractice insurance crisis, Ohio has already lost physicians and medical facilities and remains in jeopardy of further losses. Any unnecessary insult to this system must be avoided. Overcompensation following an unfair jury trial is just such an unnecessary insult.

CONCLUSION

Jurors seated in a medical negligence action assume a tremendous responsibility. They are asked to take a crash course in medicine that involves nothing more than a series of one-way lectures by “educators” who usually disagree in many respects. Armed with only this limited education, the jury is then asked to judge the propriety of a medical provider’s care and, where the care is found lacking, to determine how the patient was affected and assign a dollar value. A jury cannot be expected to accomplish this daunting task with tainted evidence. Tainted evidence absolutely precludes a fair jury trial.

The Ohio Constitution guarantees parties to litigation a fair jury trial in an Ohio courtroom. Where tainted evidence has denied litigants this fundamental right, it is incumbent upon the trial court to fashion a remedy. One such remedy is remittitur, but that remedy must be strictly limited to situations where the only evidentiary concerns deal with issues relating to the *amount* of damages awarded. Where the evidentiary concerns deal with issues relating to liability, the only appropriate remedy is to order a new trial. Because the evidentiary abuses in

¹³ Based upon financial information provided to OHA by its members Ohio hospitals provided more than \$636.5 Million in charity care and more than \$1.2 billion in total community benefit in 2004. The figures are still being finalized for 2005, but are expected to be even higher.

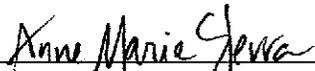
the case at bar, predominantly related to the conduct of Plaintiff's counsel, permeated damage *and* liability issues, a new trial is the only way to afford the parties the fair jury trial to which they are entitled.

The outcome of this case and the cases that follow will have an impact on Ohio's fragile health care system. Contributing to the system's fragile state are the financial strains of an insurance crisis that are only further aggravated by excessive jury verdicts. Where the excessive jury verdict is the result of an unfair jury trial, this is a strain that can and must be avoided. Ordering a new trial will afford all parties the opportunity for a fair jury trial. At the same time, it will eliminate the tainted and excessive \$30,000,000 judgment and the correlating strain that these types of judgments (and their risks) impose on a system that is already vulnerable.

Additionally, the outcome of this case will have an impact upon the conduct of attorneys practicing in Ohio courtrooms in the future. Condoning egregious behavior of counsel by allowing a verdict to stand will encourage others to do the same in order to reap similar rewards for themselves and their clients. Truth and fairness will fall victim to theatrics and histrionics. In response, this Court can expect to see similar behavior develop from opposing counsel who see no alternative. Obviously, such a situation is not conducive to the orderly administration of justice, and would leave Ohio citizens with a guarantee that they cannot get a fair jury trial in this State.

For these reasons and those stated previously herein, this Court should reverse the Eighth District Court of Appeals' decision reinstating the verdict and order a new trial.

Respectfully submitted,



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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true copy of the foregoing Brief of *Amici Curiae* Ohio Hospital Association, Ohio State Medical Association, and American Medical Association in Support of Appellants was served by ordinary U.S. mail, postage prepaid, upon the following this 4th day of December, 2006:

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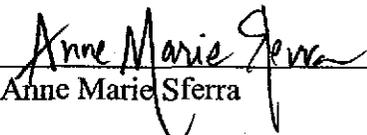
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APPENDIX

EXHIBITS

Ohio Medical Malpractice Commission's Final Report	Exhibit A
<i>Docs Find Relief at Last; Tort Reform Helps Apply Brakes to Steep Malpractice Insurance Hikes; More Physicians Staying in Ohio</i> , CRAIN'S CLEVELAND BUSINESS, Sept. 11, 2006	Exhibit B
Ohio Physicians Surgeons Medical Malpractice Rates: Selected Specialties by County (Neurological Survey)	Exhibit C
Ohio Physicians Surgeons Medical Malpractice Rates: Selected Specialties by County (OB/GYN Survey)	Exhibit D
Premiums, Losses, and Cost of Investigation and Defense Table	Exhibit E
Physician Medical Malpractice Insurance Survey	Exhibit F

**FINAL REPORT AND RECOMMENDATIONS
OF THE
OHIO MEDICAL MALPRACTICE COMMISSION**

APRIL 2005

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I. INTRODUCTION

Overview

The Ohio Medical Malpractice Commission was created in 2003 in legislation to address the medical liability crisis in Ohio. That legislation, Senate Bill ("S.B.") 281 (R-Goodman), was enacted in response to concerns that rapidly rising medical malpractice insurance premiums were driving away health care providers and compromising the ability of Ohio consumers to receive the health care they need.¹ The bill contained a comprehensive set of tort reforms aimed at addressing litigation costs and stabilizing the Ohio medical malpractice market. Governor Bob Taft signed S.B. 281 on January 10, 2003. The bill became effective on April 11, 2003.

In order to further analyze the causes of the current medical liability crisis, and to explore possible solutions in addition to tort reform, S.B. 281 created the Ohio Medical Malpractice Commission ("Commission"). The Commission is composed of nine members, including representatives of the insurance industry, health care providers, and the legal system. (Exhibit A). The Commission's first meeting was held in May 2003 and at the June meeting Commission members adopted the following mission statement:

"Provide available, affordable, and stable medical liability coverage for the Ohio Medical Community while providing for patient safety and redress for those who are negligently harmed."

The Commission's statutory requirements and mission statement indicate a desire among all members to conduct a thorough analysis of the causes of the current crisis. All Commission members are united in their intent to avert another crisis in which the health care of Ohio consumers could be compromised, and to mitigate the current crisis as possible. The Commission does note that many members voiced concern with the overall health system, including reimbursement rates for Ohio providers. Although reimbursement may be relevant to the affordability of medical liability coverage, the Commission has not examined that issue.

The enactment of S.B. 281 in Ohio was intended to respond to concerns raised by providers that Ohio medical liability insurance had become unaffordable, thereby creating a situation where medical liability insurance was no longer available to certain physicians.² Ohio's tort reform efforts were preceded by enactment of similar laws in other states. Among the states already with medical malpractice tort reform are Colorado, Indiana, Wisconsin, Louisiana, California, and New Mexico. These states are commonly referred to as "non-crisis" states as defined by the American Medical Association. A primary feature of such tort reform, including Ohio's, is caps on non-economic damages in medical malpractice lawsuits. While caps in some states include caps on economic damages (Colorado, Virginia, and Indiana) and lower caps than Ohio implemented, Ohio established caps on non-economic damages generally at \$500,000, with a \$1,000,000 cap for catastrophic injuries involving permanent and substantial physical deformity, loss of a limb or bodily organ system, or for an injury that deprives a person of independently caring for himself and performing life-sustaining activities.

Senate Bill 281 also changed the statute of repose to generally bar claims initiated more than four years after the occurrence of the act or omission constituting the basis of the claim, required a plaintiff's attorney whose contingency fees exceed the applicable amount of the limits on damages to file an application in the probate court for approval of the fees, and mandated lawsuit data reporting to the Department of Insurance.

Charge of Commission

As provided by S.B. 281, the Commission has two charges. First, the Commission is required to study the effects of the tort reforms contained in S.B. 281 on the medical malpractice marketplace. Second, the Commission is required to investigate the problems posed by, and the issues surrounding, medical malpractice. The Commission is required to submit a report of its findings to the Ohio General Assembly in April 2005.

Another piece of legislation impacting the Commission, Senate Bill 86 (R-Stivers), became effective on April 13, 2004. (Exhibit B). Senate Bill 86 added several additional charges to the Commission's mission. Those new charges require the Commission to

- Study the affordability and availability of medical malpractice insurance for health care professionals and other workers who are volunteers and for nonprofit health care referral organizations;
- Study whether the state should provide catastrophic claims coverage, or an insurance pool of any kind, for health care professionals and workers to utilize as volunteers in providing health-related diagnoses, care, or treatment to indigent and uninsured persons;
- Study whether the state should create a fund to provide compensation to indigent and uninsured persons who are injured as a result of the negligence or misconduct by volunteer health care professionals and workers; and
- Study whether the Good Samaritan laws of other states offer approaches that are materially different from the Ohio Good Samaritan Law.

Onset of the Ohio Medical Liability Crisis

In the late 1990's, the Ohio medical liability insurance market began to slip into what we now recognize as a crisis. Rapidly rising costs caused the profitability for insurers doing business in Ohio to plummet. In 1999, Ohio's medical liability insurers reported underwriting costs that were 50.2 percent higher than the premium they collected. In 2000, underwriting costs exceeded premium by 67.9 percent. (Exhibit C). Underwriting costs are those directly related to providing insurance, including claim investigation and payment, defense of policyholders and operating expenses. By 2000, companies were forced to react to the increasing costs and began to raise rates dramatically. By late 2001, insurers were leaving the market and rates were rapidly rising.

Since 2000, nine insurers have left the Ohio medical liability market. St. Paul, First Professionals, Professionals Advocate, Lawrenceville, Phico, Clarendon, CNA, Farmers, and Frontier all withdrew from Ohio and other states due to the difficulties faced in this line of business. The surplus lines market, where providers turn when admitted insurance carriers turn away business, grew significantly.

Health care providers faced increasing difficulty finding affordable medical liability insurance coverage since rates were rising rapidly. The five major medical liability insurance companies in the state, Medical Protective, ProAssurance, OHIC Insurance Company, American Physicians, and The Doctors Company, which collectively cover nearly 72 percent of the Ohio market, raised their rates dramatically. The attached exhibit shows the average rate change for Ohio "Physicians and Surgeons" since 2000. (Exhibit D). The average change in 2002 was the highest at 31.2 percent. Some areas of Ohio, such as the counties in the northeast and along the eastern border, experienced even higher increases. Medical specialties such as OB/GYNs, neurosurgeons, radiologists, and emergency/trauma providers were hit particularly hard.

Despite the rate increases, the premiums collected by medical liability insurers in Ohio have not been sufficient to cover the costs of providing insurance, such as the cost of investigation, defense and payment of claims and operating expenses. Financial reports by Ohio medical liability insurers have not shown a profit since the mid-1990's, with insurers reporting underwriting losses in each of the last five years. (Exhibit C). All five of the top insurers received downgrades from rating agencies over the last five years, and today only two have high "A-" ratings and one is unrated.

Another fact illustrating the crisis is the number of inquiries by Ohio providers and requests for help made to the Ohio Department of Insurance. Since late 2002, the Department has assisted 223 doctors regarding their medical liability insurance coverage. Many of the calls demonstrated that certain specialties such as obstetrics were particularly impacted by rate increases. Another 17 doctors asked the Medical Coverage Assistance Program (MCAP) to help them secure medical liability insurance coverage. Additionally, the Department has documented that 228 doctors have retired, reduced or eliminated high-risk procedures, or moved to another state. Of those doctors, 97 decided to drop their private practice, reduce or eliminate high-risk procedures, or otherwise change the service they provide; 68 decided to retire and 63 have moved to another state. As a result of these ongoing dialogues and concerns about the availability of physicians, the Department conducted a survey of Ohio providers to ascertain their concerns about the current crisis.

Impact of the Crisis on Doctors and Their Patients

In the summer of 2004, the Ohio Department of Insurance commissioned a survey of 8,000 doctors to understand how rising premiums affected the doctors' practices and their patients. (Exhibit E). The results demonstrated that the rising medical liability insurance costs have significantly affected physician behavior. Nearly 40 percent of the 1,359 doctors who responded to the survey indicated that they have retired or plan to retire in the next three years due to rising insurance costs, yet only 9 percent of the respondents were over age 64.

Northeast Ohio can anticipate the highest number of those retirements, with more than 40 percent of the local physicians planning to leave in the next three years.

Ohio's patient population is being impacted, with a significant reduction in patient services already having occurred. Sixty-six percent of doctors surveyed indicated that they have turned down high-risk procedure patients or have referred those patients elsewhere. The situation is critical in southeast Ohio, where 95 percent of doctors surveyed have declined or referred high-risk patients. In northeast Ohio, 48 percent of OB/GYN and family practice physicians reported they have stopped delivering babies due to high medical liability insurance costs. Over half of the osteopathic doctors who responded indicated that they are no longer delivering babies.

Rising insurance costs also have affected where doctors see patients. Doctors have reduced the number of patients they see in nursing homes and in home care and hospice settings. Southeast and northeast Ohio have been hit particularly hard with 60 percent of responding southeast Ohio doctors having cut their in-home visits, and 54 percent of responding northeast Ohio doctors reporting that they have done the same. Responding doctors also indicated that, as a result of these high medical liability premium costs, they are being forced to see more patients to remain financially viable and many are cutting staff. In short, the survey reported that high medical liability premiums are having an effect on health care services in Ohio, and that Ohio could soon face a crisis of access to care.

Initial Signs of Recovery

The Ohio medical liability market is beginning to show signs of recovery. Two new medical liability companies, OHA Insurance Solutions, Inc. and Healthcare Underwriters Group Mutual of Ohio, have been licensed in Ohio in the last year and a half. The five major medical liability insurers in the Ohio market have stayed in Ohio throughout these difficult times. These companies indicated to the Commission during a joint legislative hearing on April 19, 2004 that among other factors, Ohio's enactment of medical malpractice tort reform legislation made them more confident about the future of Ohio's medical liability marketplace.

Medical liability rates appear to be slowly stabilizing. In 2004, rates for the top five companies increased an average of 20 percent. The average increase, while still high, is smaller than that of the two previous years. So far in 2005, two of the top five insurers, Medical Protective and The Doctors Company, have filed and implemented rate changes averaging 12 percent. Moreover, in the past year, some of these insurers have filed decreases for some regions of the state. The Doctors Company lowered rates for General Practice by 1 percent in northwest and in southeast Ohio, and by 9 percent in central and southwest Ohio. Medical Protective filed a decrease of 3 percent for General Practice in northeast Ohio. By the end of 2005, Ohio may see average rate changes below 10 percent.

Ohio medical liability insurers are also slowly moving toward profitability, which helps ensure that the medical liability companies will remain in the market and will fulfill their financial obligations to their policyholders. Underwriting losses have steadily

decreased since 2000. (Exhibit C). While the latest year's results are not yet available, continued movement toward profitability is expected and the industry could report an operating profit for 2004 in Ohio. If that occurs, this will be the first year since 1997 that Ohio's medical liability insurance industry has reported a profit.³

Still in Crisis

While the Ohio medical liability market is beginning to recover, it is still in a state of crisis. Positive signs in the marketplace do not mean that doctors are no longer facing extremely high premiums. Although rate increases are stabilizing, doctors in Ohio are still suffering from the effects of rising rates. Premiums are overall much higher than they were just five years ago. For example, rates for OB/GYNs in Cuyahoga County for the top five companies averaged \$60,000 in 2000. Now the average is \$145,000. In Athens County, the average rate for neurosurgeons was \$54,000 in 2000. Today the average is \$125,000. General surgeons in Franklin County paid an average of \$33,000 in 2000, and now face an average premium of \$68,000.⁴

The continuing difficulties in finding affordable medical liability insurance coverage raise concerns that health care providers, particularly those in high-risk specialties, will further limit care, leave Ohio, or leave the profession entirely. Ohio health care consumers may experience increasing difficulty seeing the provider of their choice. Costs to consumers may also rise if providers defensively over-prescribe, over-treat, and over-test their patients to avoid potential lawsuits.

II. FINDINGS AND RECOMMENDATIONS OF THE COMMISSION

In this environment, the Commission held 26 meetings over a two-year period in order to meet its statutory charges. Speakers with expertise on particular medical malpractice-related topics were invited to testify before the Commission. The Commission heard testimony from actuaries, doctors, state regulators and other experts. A list of the Commission's meetings, the topics covered, and the witnesses who testified before the Commission is attached. (Exhibit F). Based upon a review of the testimony, the Ohio Medical Malpractice Commission makes the following findings and recommendations.⁵

A. Effects of Senate Bill 281

The Commission concludes that because of the nature of ratemaking - primarily relying on loss experience over a period of time - and the fact that most medical malpractice cases now being heard in Ohio courts are not subject to S.B. 281 because they were brought and/or arose before its effective date, the Commission cannot conclusively evaluate the effects of the new law on the Ohio market, or on medical malpractice cases in Ohio.

However, based on testimony and data from states that do have tort reform in place, the Commission fully expects tort reform to have a stabilizing impact on the medical malpractice market in Ohio over time. Insurance department representatives from Indiana, Wisconsin, and New Mexico testified about the positive impact damage caps and patient

compensation funds have had on their respective markets and statistics from those states and Louisiana show their relative market stability compared to Ohio's. (Exhibit G). In addition, the Texas commissioner testified that an in-house, peer reviewed study of their recent tort reform, which included a \$250,000 cap on non-economic damages, estimated a 12 percent reduction in medical malpractice rates. Countrywide, those states with longstanding tort reform have more stable markets than Ohio's, and the American Medical Association's designation of non-crisis states also reflects this fact. (Exhibit H).

In addition, at the Commission's joint meeting with members of the House and Senate Insurance Committees on April 19, 2004, representatives of the five major medical liability insurers in Ohio (which hold about 70 percent of the market share) testified. Several indicated their increased confidence in operating in Ohio in light of the passage of medical malpractice tort reform, notwithstanding the fact that the industry has been losing money in Ohio since 1998. (Exhibit C). The Director of Insurance also has reported to the Commission that Department conversations with these insurers over the last two years indicate that a major reason they are still operating in Ohio is the passage of tort reform, since they are not compelled to remain in the market but are more optimistic the market will improve with tort reform.

RECOMMENDATION:

The Commission strongly recommends that S.B. 281 remain in effect in Ohio with the expectation that it will help to stabilize the medical malpractice market over time.

B. Ratemaking

The Commission heard testimony about ratemaking. Testimony included discussion of the ratemaking process, Department review of medical malpractice rate filings, various rate review standards such as "prior approval" and "file and use," and the role of investment income on ratemaking.

The Commission acknowledges and agrees with the testimony of most witnesses, including insurance actuaries, that the primary driver of medical malpractice rates is the costs associated with losses and defense of claims. For the three most recent years of financial reports, these costs have exceeded premiums collected by the top five medical malpractice insurance companies in Ohio by an average of 23.7 percent and have increased by 57 percent (241,488,088 to 378,313,587). (Exhibit I). In the last five years, rates for those insurers have increased more than 100 percent. (Exhibit D). The entire medical liability insurance industry has lost money in Ohio since 1998. (Exhibit C). Profit figures in Ohio for 2002 and 2003 show that the costs to provide this insurance exceeded premium by 46 percent in 2002 and by 30 percent in 2003.

Allegations that investment losses have caused the rapid rise in medical malpractice premiums in Ohio in the last several years are without basis. Returns on investments have been about 4 percent to 5 percent since 1999. Ohio law and regulation prohibit the recoupment of investment losses in prospective rates, and the Department ensures through

its rate review that this does not occur. ORC §3937.02 (D). Further, investment income primarily plays a part in ratemaking with respect to the estimated return on funds placed in reserves, to determine whether sufficient reserves, including investment earnings, will be available to pay claims. The Department reviews companies' estimates used in these calculations carefully.

Ohio's regulatory system for property and casualty rates is known as "file and use," meaning that while companies must file their rates with the Department, they may use them immediately. The Department can reject rates if after review the Department determines the rates are unfairly discriminatory, inadequate or excessive. Other states have different systems, such as "use and file" (no prior review) and "prior approval" (requiring insurance department approval before use). None of these systems appears to be distinctive in improving rates or insurance markets. In fact, according to some companies, prior approval often results in delays and political bickering before rate changes can be implemented, potentially impacting a company's financial condition. This concerns insurance regulators who also oversee the financial condition of insurance companies to protect consumers.

No legal requirement exists to compel companies to file their rate changes on a regular basis, although the practice in Ohio's volatile medical liability market has been for companies to file rate changes at least annually, and usually before a change has become effective to allow the Department time to review it beforehand. The Department has implemented procedures in the last two years to intensify scrutiny of rates and to hold companies accountable for proposed increases.

In addition, no legal requirement exists to compel companies to remain in Ohio. Despite the hard Ohio market and lack of profits in medical liability coverage, five major companies have remained in Ohio, two more have been licensed in the last year, and 32 additional companies continue to write at least \$1 million in coverage each. This is a more positive trend following the departure of nine companies from Ohio between 2000 and 2002.

RECOMMENDATIONS:

- 1.) The Commission does not recommend a change in the rate review system in Ohio since rates are well regulated.
- 2.) The Commission recommends that the Department require medical malpractice companies to file and justify their rates, even if no change is requested, at least once every year.

C. Data Collection

Senate Bill 281, the tort reform bill, required clerks of court to report medical malpractice lawsuit data to the Department, which developed a system for collecting the data. However, testimony of the Department and county clerks indicated the insufficiency and unreliability of the data collected under that system. As a result, the Commission

recommended in its Interim Report the passage of legislation requiring more comprehensive data reporting.

Subsequently, House Bill 215 (R-Schmidt) was enacted September 13, 2004, requiring detailed data reporting to the Department by insurance companies and self-insureds. The Department recently promulgated O.A.C. 3901-1-64, effective January 2, 2005, implementing H.B. 215 and requiring medical malpractice insurers and others who assume liability to pay medical, dental, optometric, and chiropractic claims to report judgment, settlement and other closed case data to the Department. Further, H.B. 425 (R-Stewart, effective April 27, 2005) contained uncodified language requesting the Ohio Supreme Court to adopt a rule requiring attorneys to report fee expense information to the Department.

The Commission concludes that the new data reporting and collection requirements appear to be comprehensive and sufficient at the present time but should be evaluated after being fully implemented to determine whether additional changes are warranted.

Confidentiality of data continues to be an issue, however. The Commission agrees that the data should remain confidential, except in the aggregate. Members expressed concern that if specific individual case data were released, insurers might not be as forthcoming with accurate data and individual medical providers could be put at some risk. Two members believe that raw data should be available so that the public can draw its own conclusions.

RECOMMENDATIONS:

- 1.) The new data collection provisions of H.B. 215, O.A.C. 3901-1-64, and H.B. 425 should be evaluated annually after each annual cycle of data has been collected. The annual report by the Department required by H.B. 215 should provide the basis for this evaluation.
- 2.) Data collected should remain confidential as required by current law.

D. Medical Error Reduction

While long known to members of the medical and legal profession, errors in the delivery of health care occur. The Institute of Medicine report issued in 2000 entitled *To Err is Human: Building a Safer Health System* focused attention on this issue. In addition, although redundancies and checks within the health care delivery system help reduce error, medical errors do occur. Whether or not most errors result in lawsuits is not clear, although a 1991 New England Journal of Medicine article evaluating a 1984 New York study indicated that only 7.7 percent of actual cases of error result in lawsuits. In addition, a 2003 GAO report estimates that 70 to 86 percent of all medical malpractice verdicts result in no payment, suggesting that not all cases are deemed meritorious.

The Commission heard testimony regarding several initiatives occurring in Ohio to address medical error. A major initiative in this area jointly sponsored by the Ohio State Medical Association, the Ohio Osteopathic Association, and the Ohio Hospital Association is the Ohio Patient Safety Institute. This organization, formed in 2000, has investigated the development of a statewide system for reporting medical errors and has undertaken a variety of initiatives to raise the awareness of participants in healthcare delivery throughout the state to patient safety and the need for improvement. Another initiative was presented to the Commission by the Ohio University College of Osteopathic Medicine, which has developed a Patient Safety Committee to research the causes of error and promote a culture of safety. Commission member Frank Pandora pointed out that most large hospitals and hospital systems have initiatives to reduce error in health care delivery underway. The Ohio State Medical Board also has an interest in reducing medical error and a responsibility to investigate medical error brought to it in the form of complaints received. The Medical Board testified that it lacks sufficient resources to investigate all complaints received in a timely fashion.

The Commission heard testimony that much of the work in the area of patient safety is based on a "systems" approach to the reduction of medical error. The approach recognizes that the occurrence of an error in the delivery of health care may involve the failure of a system to perform appropriately rather than the failure of a single or small number of members of the health care delivery team. Such an approach does not necessarily de-emphasize individual responsibility but recognizes that systems should be designed to reduce the opportunity for error to occur, and in order to improve must go beyond the emphasis on individual blame.

In addition, the Commission heard testimony that improving the structure of the health care delivery system to improve safety will require extensive capital investment in the near future. Improving data systems and investment in technology to improve safety will need capital resources currently unavailable to many participants in the system. The Commission encourages the exploration of creative ways for state government to assist in the capital investment in the health care delivery system to make it the safest possible system.

Ohio lacks a statewide uniform medical error reporting protocol, requirement or system. Although the Joint Commission on Accreditation of Health Care Organizations imposes reporting requirements of so-called sentinel events on its accredited hospitals, these requirements do not extend to the outpatient environment and do not cover the entire scope of "medical errors."

The Commission also finds that, in spite of efforts by organizations described above, the state does not have an adequately funded, centralized system for the evaluation and dissemination of best practices in the area of patient safety. Six states have established "patient safety centers" with varying oversight and funding but all with a general mission of educating health care providers on best practices. The intended goals of such a center in Ohio would be to coordinate patient safety efforts at institutions across the state, work to identify best practices in patient safety, educate health care providers about best practices,

identify funding sources for the implementation of best practice strategies, develop data collection systems and protocols for error reporting and make appropriate recommendations to the legislature concerning the funding of such activities. Such a center should be structured as a partnership among appropriate state government units and appropriate private institutions, organizations and associations.

The Commission strongly believes there is a need for a coordinated and directed effort in medical error reduction. An important step would be the development of a medical error reporting system to allow the systematic study of the errors occurring to develop appropriate response to them. Confidentiality of data needs to be addressed. Members expressed concern that if specific individual patient, physician and hospital data were released, as opposed to aggregate data, such release may weaken the reporting of medical errors. The improvement of patient safety in Ohio is an important and appropriate goal and will require governmental support and partnerships with components of the health care delivery system.

The Commission believes that cooperative ventures among the Department of Health, the Ohio State Medical Board, other agencies, private institutions and organizations may be fostered to develop and implement a statewide protocol for medical error reporting and a statewide repository for such information. This would require legislation mandating and funding such an initiative, which would add legitimacy to this effort.

RECOMMENDATION:

The Commission strongly recommends the creation of a "patient safety center" as described above which would include the development of a medical error disclosure to patients protocol and a statewide uniform medical error reporting system.

E. Health Care Access, Recruitment, and Retention

The Commission heard specific testimony from leaders at medical education institutions in Ohio that recruitment of new doctors and retention of experienced doctors, particularly in certain specialties like surgery and obstetrics, have been impacted by the medical malpractice crisis. In addition to anecdotal evidence from doctors and hospitals across the state, the Doctors' Survey commissioned by the Department in the summer of 2004 reflected the alarming response from almost 40 percent of doctors responding to the survey that they have retired or plan to retire in the next three years due to rising insurance expenses. The Doctors' Survey also indicated an impact on health care access because of doctors' increasing unwillingness to conduct certain high-risk procedures or to see patients in certain locations (such as nursing homes) and doctors' increasing practice of ordering more tests to defend their medical decisions.

The State Medical Board testified that the number of licensed doctors in Ohio is increasing, but it does not keep track of the number of licensed doctors who are retired, who moved their practices to another state, or who have otherwise limited their practice by curtailing high-risk procedures.

The Commission concludes that a correlation exists between the medical malpractice crisis and access to health care and recruitment and retention of doctors. The efforts of the Department and legislature to stabilize the medical malpractice market should help Ohio retain physicians in the long-term. Various institutions are exploring their own initiatives to retain and recruit physicians, including providing coverage through captives and risk retention groups.

RECOMMENDATIONS:

- 1.) The Commission recommends the investigation of programs to forgive educational loans and other incentives for doctors in certain specialties and for those doctors who agree to stay in Ohio for a specified period of time.
- 2.) The State and the Department should continue to monitor patient access to health care and doctor departures, and advise appropriate parties and agencies of such issues.

F. Patient Compensation and Other Compensation Funds

The Department conducted a feasibility study of patient compensation funds in 2003 (Pinnacle Report) pursuant to the directive in S.B. 281, and hired another consultant in 2004 to develop specific models for a patient compensation fund (PCF) in Ohio (Milliman Report). Milliman recommended that an Ohio PCF provide coverage over a primary layer of \$500,000, up to \$1 million in coverage, and require participation by all health care providers, including self-insured providers, which would pay premiums to fund the PCF. The Milliman report concluded that the anticipated change in overall premium based on the recommended model would be about a 5 percent reduction. The Department's position is that the long-term stabilizing impact of a PCF warrants its serious consideration, but other Commission members were not persuaded by this argument. However, Commission members did recognize the thorough research of the Department and Commission on PCFs. Members do not believe that a PCF with only a 5 percent possible reduction in premiums would be beneficial. Ohio healthcare providers indicated they sought a more significant impact on premiums for them to support implementation of a PCF.

The Commission also heard testimony on two specialized funds in Virginia and Florida for birth-related injuries. No information appears to be available in Ohio on the extent of these types of cases.

RECOMMENDATION:

The Commission recommends that no further action on a PCF, funded solely by health care providers, be taken at this time.

G. Captive Initiative

The Department has developed legislation that would permit the formation of and provide for the regulation of captive insurers in Ohio. The Commission heard testimony about the advantages of captives - among other benefits, cheaper rates because of lower administrative costs - but discussed the need for financial standards and oversight in Ohio to protect doctors and patients. The Commission believes that such legislation could increase insurance capacity in Ohio, particularly needed in the medical liability market.

States like Vermont and South Carolina have captive statutes which allow captives to write a wide range of commercial coverage, not just medical liability. These states have attracted more companies to form captive insurers in their states rather than in offshore jurisdictions.

RECOMMENDATION:

The Commission recommends that the Department continue to investigate captive formation in Ohio, which could result in related legislation.

H. Non-Meritorious Lawsuits

The Commission recognizes that claims, settlements and lawsuits generate costs for insurance companies, whether or not any money is paid out to the claimant. The Commission heard considerable testimony that these cost factors drive premium increases. The failure to mitigate these costs will impact a provider's liability premium regardless of the underlying merits of the lawsuits involved.

Consistent with these concerns and recommendations made in the Commission's Interim Report, the General Assembly enacted H.B. 215 (effective September 13, 2004) which requested the Ohio Supreme Court's implementation of a rule of civil procedure requiring an affidavit of merit for the plaintiff at the initial filing of a medical malpractice case. The Supreme Court has finalized amended Civil Rule 10, which will be effective July 1, 2005. In addition, H.B. 215 provided for the filing of affidavits of non-involvement to excuse certain named parties, with the goal of dismissing certain inappropriate parties earlier in the process, thereby reducing associated costs. This provision became effective September 13, 2004.

Finally, H.B. 215 gives the Ohio State Medical Board disciplinary authority over out-of-state medical experts who come into the state to testify. This provision allows the Medical Board to monitor the caliber and veracity of medical experts in an effort to curtail unqualified "experts" from lending ostensible credibility to non-meritorious lawsuits.

The Commission also heard testimony on the viability of binding arbitration, pretrial screening panels, and medical review boards. The Commission research indicates many issues still need to be resolved regarding these proposals, including whether they are constitutionally feasible, reduce costs or save time. Evidence from states which currently

employ such measures was not conclusive on these issues. A pilot program for a less formal mediation alternative could avoid many of the constitutional issues which surfaced in the debate over pretrial screening panels and could be tested through the pilot program to evaluate its effectiveness.

RECOMMENDATIONS:

- 1.) The Commission recommends a pilot project of a less formal mediation alternative in conjunction with the Supreme Court.
- 2.) Although cost is a factor (typically a specialized court costs \$100,000 per year per county), the Commission recommends a pilot project in one or more counties that establishes medical malpractice courts or dockets, which may provide increased efficiency and competency.
- 3.) The Commission recommends that the process reforms enacted in H.B. 215 be evaluated by the Supreme Court after they have been in effect for two years to determine their impact on medical malpractice cases. This evaluation should be reported to the Governor, legislative leadership, and the Department.

I. Charitable Immunity

The Commission was given a new task in Senate Bill 86 of the 125th General Assembly, which extended the charitable immunity law to volunteer health care professionals regardless of where they provide the service. The Commission was directed to review the following and finds accordingly with respect to each issue:

(1) The affordability and availability of medical malpractice insurance for health care volunteers and nonprofit health care referral organizations: According to testimony before the Commission, 87 percent of the members of the Ohio Association of Free Clinics find it difficult to access affordable professional liability coverage despite both the existence of Ohio's charitable immunity law and no lawsuits filed against Ohio free clinics. At least one Ohio medical liability insurance carrier is offering coverage for free clinic staff.

(2) The feasibility of state-provided catastrophic claims coverage to health care workers providing care to the indigent and uninsured: The Commission heard testimony from Virginia and Iowa, states that indemnify or provide state coverage for charitable providers. Ohio currently only indemnifies its state employees and does not have a statutory mechanism to indemnify others. To provide indemnification or to pay premiums would be a significant funding issue in Ohio.

(3) The feasibility of a state fund to provide compensation to persons injured as a result of the negligence of health care volunteers: Providing a state fund to compensate injured persons would also face funding hurdles. Further, since no claims have been made against Ohio free clinics, the Commission does not believe that a state fund to provide

compensation to persons injured as a result of the negligence of health care volunteers is currently warranted.

(4) Other states' Good Samaritan laws: The Commission also learned that Ohio's approach to charitable immunity is comparable to a majority of other states' approaches.

The Commission finds that S.B. 86 is a good step toward encouraging charitable care in Ohio. However, free clinics still have difficulty obtaining affordable medical liability coverage, even though no claims have been made against Ohio free clinics.

RECOMMENDATIONS:

- 1.) The Commission recommends the issuance of guidelines by the Ohio Department of Insurance which would require medical liability insurance carriers to incorporate into their underwriting and pricing of policies for free clinics appropriate modifications to reflect past and prospective claim experience in Ohio.
- 2.) The Commission recommends the inclusion of free clinics in a statewide medical error reporting system in order to ensure that patients are receiving the best care possible.

J. Medical Liability Underwriting Association

House Bill 282 (R-Flowers, enacted April 4, 2004) provided for the transfer of the \$12 million previously held by the 1975 Ohio Joint Underwriting Association into a new fund that could be used to create a new medical liability company or to fund other medical malpractice initiatives as approved by the Ohio General Assembly. The legislation also gave the Director of Insurance authority to create a Medical Liability Underwriting Association ("MLUA") if the current medical malpractice market were to further deteriorate. The MLUA would write primary insurance coverage for doctors unable to find coverage.

RECOMMENDATION:

Due to the unpredictable and volatile nature of the medical malpractice market, and the Department's recent testimony on stabilizing but still uncertain market conditions, the Commission strongly urges the legislature to retain the current funding set aside for the potential enactment of the MLUA and for future medical malpractice initiatives.

K. Miscellaneous Recommendations

- 1.) During the hearings, several physician witnesses testified on the difficulty of affording the current premiums for professional liability coverage. Even more troublesome than the current pricing is the necessity of purchasing prior acts or "tail" coverage to protect and maintain existing coverage limits after retirement or changing companies. Under previous custom a company would grant a deceased,

disabled or retiring practitioner continuing coverage for any events/claims occurring during the existence of the policy's terms at no additional cost. Medical liability insurers traditionally provided tail coverage as a prepaid component of prior premiums. Companies require an amount equal to 1-2 years of mature premium prior to the physician retiring before the end of the five-year vesting period, or changing from one company to another. Additionally, market conditions have forced some physicians to switch professional liability companies several times, creating the necessity of purchasing of multiple tail policies.

According to comments by Texas Insurance Commissioner Jose Montemayor, the state of Texas has a mechanism to address part of this problem. When a company that sold policies in Texas leaves and refuses to offer a tail policy for a physician's liability coverage, the existing Texas Joint Underwriting Authority ("JUA") is authorized to provide that tail policy coverage to the physician when he or she purchases primary coverage from the JUA.

As stated earlier in this report, nine companies left Ohio between 2000 and 2002, forcing their policyholders to find tail liability policies from those companies even if the companies' financial conditions were questionable or the companies were no longer doing business in the state. Ohio has already recognized the importance of maintaining the availability of medical professional liability insurance by creating the statutory authority to establish the MLUA. The MLUA would provide primary coverage in case the remaining carriers were to decide to leave Ohio or limit their participation in the market.

The Commission recommends that the Department of Insurance investigate the economic implications of the MLUA or another state insurance entity providing prior acts or tail coverage if the original insurer has become insolvent or stopped doing business in the state. The results of this investigation could provide the basis for legislation.

- 2.) The Commission recommends that if the Department determines that the long-term medical malpractice market has stabilized and the future funding of an MLUA is unnecessary, then the current MLUA funding should be directed to fund other medical malpractice initiatives.
- 3.) The Commission recommends that the Department continue to monitor the medical liability market in Ohio, and recommends that biennially, beginning two years after issuance of this report, the Department provide a market analysis of the medical liability market to the Governor and the legislature.

¹ Senate Bill 281 (124th General Assembly, enacted April 11, 2003), section 3(B)(1) and (2): "[T]he General Assembly declares its intent to accomplish all of the following by the enactment of this act: (1) To stem the exodus of medical malpractice insurers from the Ohio market; [and] (2) To increase the availability of medical malpractice insurance to Ohio's hospitals, physicians, and other health care practitioners, thus ensuring the availability of quality health care for the citizens of this state. . . ."

² Senate Bill 281 (124th General Assembly, enacted April 11, 2003), section 3(A)(3)(c): "As insurers have left the market, physicians, hospitals, and other health care practitioners have had an increasingly difficult time finding affordable medical malpractice insurance. Some health care practitioners, including a large number of specialists, have been forced out of the practice of medicine altogether as a consequence. The Ohio State Medical Association reports 15 percent of Ohio's physicians are considering or have already relocated their practices due to rising medical malpractice insurance costs."

³ "State of the Medical Malpractice Market," Ohio Department of Insurance Director before the Ohio Medical Malpractice Commission, February 28, 2005.

⁴ Top five companies' medical malpractice 2000-2004 rate filings submitted to the Ohio Department of Insurance.

⁵ Minority views will be expressed separately.

Docs find relief at last
Tort reform helps apply brakes to steep malpractice insurance hikes; more physicians staying in Ohio

By SHANNON MORTLAND

6:00 am, September 11, 2006

Many Ohio doctors finally can exhale.

For several years, physicians have held their breath each time they renewed their medical malpractice insurance, wondering if rates would rise 20%, 30% or more. However, medical liability insurance rates in the state finally have begun to level off - and even decline slightly - after years of climbing to levels that were some of the highest in the country.

"The market really appears to be slowly stabilizing," said Ann Womer Benjamin, director of the Ohio Department of Insurance. "Rates for the five major medical liability companies in Ohio show an average decrease of 1.5%. That follows significant increases in the past six years."

Just two years ago, doctors were fleeing the state and closing or limiting their practices because they no longer could afford Ohio's malpractice rates. Cuyahoga County was especially hard hit, as local hospitals lost specialists such as obstetrician-gynecologists, neurosurgeons and cardiologists.

That's no longer the case, said Tim Maglione, senior director for government relations at the Ohio State Medical Association, the professional group for Ohio's doctors.

"We're not getting the phone calls and letters from doctors who say they've got to pick up and leave Ohio," he said.

Mr. Maglione and Ms. Womer Benjamin both credit the moderation in malpractice rates to the tort reform bill that was passed by the state Legislature in 2003. The bill limited the amount of noneconomic damages awarded in medical malpractice cases to \$250,000 or three times the plaintiff's economic loss, not to exceed \$350,000.

Ms. Womer Benjamin said the CEOs of the five medical malpractice insurers that together account for an estimated 60% of the malpractice coverage in Ohio have told her in recent weeks that the market has "greatly improved" since the bill was enacted.

"There has been a slight decrease in frequency of (malpractice) cases filed," she said. "They are seeing fewer frivolous lawsuits."

Since the tort reform bill passed, there also haven't been as many "runaway verdicts" that

awarded huge sums of money to the plaintiffs in medical malpractice cases, Ms. Womer Benjamin said.

Make way for new players

The improved market even has prompted a sizable medical malpractice insurer to enter the Ohio market.

Ace American Insurance Co. of Philadelphia last month partnered exclusively with Toledo-based insurance broker Hylant Group to market its insurance in Ohio for physicians, said Richard Hylant, president of Hylant Group Toledo. Ace provides medical liability insurance to individual physicians, hospitals and health systems, as well as to companies in the biotechnology, pharmaceutical, research and medical device fields.

Ace's interest in Ohio is quite a shift from a few years ago, when insurance companies were halting their medical malpractice business in the state due to high jury verdicts. Ms. Womer Benjamin said she has licensed one other company to issue medical malpractice insurance in Ohio in the last two years. Before that, new companies had not entered Ohio since the early 1990s, she said.

Still, the Ohio medical liability market isn't completely healed, said Dr. John Bastulli, an anesthesiologist at St. Vincent Charity Hospital and chairman of the legislative committee at the Academy of Medicine Cleveland/Northern Ohio Medical Association. The association represents 4,000 local physicians.

"There are a large number of (medical) residents that aren't going to stay in Ohio because of medical liability insurance," and some don't even want to train here, Dr. Bastulli said.

Even the doctors who remain are struggling to pay rates that have stabilized at their peak, Dr. Bastulli said. That's why the Ohio State Medical Association has refocused its energy on helping doctors better manage the costs of running their practices, Mr. Maglione said.

"While rates may be stabilizing, they're still very expensive," he said. "Physicians have to find ways to not only keep up with that expense, but the economics of their practice."

Mr. Maglione said the association also is focusing on medical malpractice cases that go to court. Ohio law allows defendants to recoup the money they spent defending themselves in a lawsuit if the court deems that lawsuit frivolous. The association helps those defendants bring sanctions against the attorney who brought the frivolous case to court, he said.

State keeps up the pressure

Ms. Womer Benjamin said the Ohio Department of Insurance also isn't resting.

The department has implemented more comprehensive reviews of insurance rates, and Ms. Womer Benjamin now personally reviews any property and casualty insurance rate change request that is 5% or more. This year also is the first year that each insurance company doing business in Ohio annually must justify its rates, even if the insurer isn't requesting rate increases, she said.

Meanwhile, Ohio doctors are pushing Senate Bill 88, which would establish a pilot project in Northeast Ohio under which all medical malpractice cases would go through a mandatory arbitration process before going to trial.

Under the bill, which passed the Senate in May, each side in a medical malpractice complaint would select an arbiter, and a chairperson would choose a third person to serve on an arbitration panel. The idea is to reduce the time and money it takes to go to trial, as well as to deter frivolous lawsuits.

**Ohio Physicians Surgeons Medical Malpractice Rates
Selected Specialties by County as of**

November 01, 2005
Fully Mature Claims Policy, \$1M / \$3M limits
Neurological Surgery

County	Company & Effective Date	Medical	Medical	OHIC	American	The Doctors
		Physiologic 8/1/05	Assurance 5/1/05	8/1/05	Physicians Assurance 11/1/05	Company 11/1/04
Class Code		8	80152	80152	162	
1 Adams	134,532	96,938	112,430	85,350	103,990	
2 Allen	134,532	128,784	112,430	126,444	139,622	
3 Ashland	134,532	128,784	112,430	126,444	139,622	
4 Ashland	201,810	173,367	157,402	227,599	165,012	
5 Athens	134,532	128,784	112,430	126,444	139,622	
6 Auglaize	134,532	128,784	112,430	126,444	139,622	
7 Belmont	141,269	147,891	112,430	139,088	139,622	
8 Brown	107,631	96,938	112,430	85,350	103,990	
9 Butler	107,631	96,938	140,538	85,350	103,990	
10 Carroll	134,532	128,784	112,430	126,444	139,622	
11 Champaign	134,532	96,938	112,430	103,694	103,690	
12 Clark	134,532	96,938	112,430	103,694	103,990	
13 Clermont	107,631	96,938	112,430	85,350	103,990	
14 Clinton	107,631	96,938	112,430	85,350	103,990	
15 Columbiana	141,269	147,891	157,402	139,088	165,012	
16 Coshocton	134,532	128,784	112,430	126,444	139,622	
17 Crawford	134,532	128,784	112,430	126,444	139,622	
18 Cuyahoga	201,810	189,105	157,402	252,888	183,338	
19 Darke	107,631	96,938	112,430	103,694	103,990	
20 DeLaware	134,532	128,784	112,430	128,444	139,622	
21 DeLaware	194,532	128,784	112,430	126,444	139,622	
22 Erie	201,810	128,784	112,430	126,444	139,622	
23 Fairfield	134,532	128,784	112,430	126,444	139,622	
24 Fayette	134,532	128,784	112,430	126,444	103,990	
25 Franklin	141,269	128,784	112,430	126,444	103,990	
26 Fulton	134,532	128,784	112,430	126,444	139,622	
27 Gallia	134,532	128,784	112,430	126,444	139,622	
28 Geauga	201,810	173,367	157,402	227,599	165,012	
29 Greene	107,631	96,938	112,430	103,694	103,990	
30 Guernsey	134,532	128,784	112,430	126,444	139,622	
31 Hamilton	107,631	96,938	101,187	86,350	103,990	
32 Hancock	134,532	128,784	112,430	126,444	139,622	
33 Hardin	134,532	128,784	112,430	126,444	139,622	
34 Harrison	134,532	128,784	112,430	126,444	139,622	
35 Henry	134,532	128,784	112,430	126,444	139,622	
36 Highland	134,532	96,938	112,430	85,350	103,990	
37 Hocking	134,532	128,784	112,430	126,444	139,622	
38 Holmes	134,532	128,784	112,430	126,444	139,622	
39 Huron	134,532	128,784	112,430	126,444	139,622	
40 Jackson	134,532	96,938	112,430	85,350	103,990	
41 Jefferson	141,269	147,891	112,430	139,088	139,622	
42 Knox	134,532	128,784	112,430	126,444	139,622	
43 Lake	201,810	173,367	157,402	227,599	165,012	
44 Lawrence	134,532	96,938	112,430	85,350	103,990	
45 Licking	141,269	128,784	112,430	126,444	139,622	
46 Logan	134,532	128,784	112,430	126,444	139,622	
47 Lorain	201,810	186,105	157,402	252,888	183,338	
48 Lucas	134,532	128,784	112,430	126,444	139,622	
49 Madison	134,532	128,784	112,430	126,444	103,990	
50 Mahoning	201,810	173,367	157,402	227,599	183,338	
51 Marion	134,532	128,784	112,430	126,444	139,622	
52 Medina	201,810	154,280	167,402	145,411	165,012	
53 Meigs	134,532	128,784	112,430	126,444	139,622	
54 Mercer	134,532	128,784	112,430	126,444	139,622	
55 Miami	107,631	96,938	112,430	103,694	103,990	
56 Monroe	141,269	147,891	112,430	139,088	139,622	
57 Montgomery	107,631	96,938	112,430	103,694	103,990	

Ohio Department of Insurance
Office of Property Casualty Services
Med Mal Rate Comparison 11-01-05

Ohio Physicians Surgeons Medical Malpractice Rates Selected Specialties by County as of

November 01, 2005

Full Year Claims Made Policy, \$1M / \$3M limits

Neurological Surgery

Company & Effective Date Class Code Classification	Medical Protective 6/1/05	Medical Assurance 5/1/05	OHIC 6/1/05	American	
				Physicians Assurance 1/1/05	The Doctors Company 1/1/04
Country	8	15	8	152	
58 Morgan	134,532	128,784	112,430	128,444	139,622
59 Morrow	134,532	128,784	112,430	128,444	139,622
60 Muskingum	134,532	128,784	112,430	128,444	139,622
61 Noble	134,532	128,784	112,430	128,444	139,622
62 Ottawa	134,532	128,784	112,430	128,444	139,622
63 Paulding	134,532	128,784	112,430	128,444	139,622
64 Perry	134,532	128,784	112,430	128,444	139,622
65 Pickaway	134,532	128,784	112,430	128,444	103,980
66 Pike	134,532	88,838	157,402	85,350	103,980
67 Portage	201,810	173,387	157,402	227,589	183,338
68 Preble	107,631	96,898	112,430	103,694	103,980
69 Putnam	134,532	128,784	112,430	128,444	139,622
70 Richland	134,532	128,784	112,430	128,444	139,622
71 Ross	134,532	96,938	112,430	85,350	103,980
72 Sanikubly	134,532	128,784	112,430	128,444	139,622
73 Scioto	134,532	88,838	112,430	85,350	103,980
74 Seneca	134,532	128,784	112,430	128,444	139,622
75 Shelby	107,631	128,784	112,430	128,444	139,622
76 Stark	201,810	154,280	157,402	145,411	165,012
77 Summit	201,810	164,280	157,402	145,411	185,012
78 Trumbull	201,810	173,387	157,402	227,589	183,338
79 Tuscarawas	134,532	128,784	112,430	128,444	139,622
80 Union	134,532	128,784	112,430	128,444	139,622
81 Van Wert	134,532	128,784	112,430	128,444	139,622
82 Venlon	134,532	88,838	112,430	85,350	103,980
83 Warren	107,631	96,898	112,430	85,350	103,980
84 Washington	141,269	147,891	112,430	139,088	139,622
85 Wayne	201,810	128,784	157,402	128,444	139,622
86 Williams	134,532	128,784	112,430	128,444	139,622
87 Wood	134,532	128,784	112,430	128,444	139,622
88 Wyandot	134,532	128,784	112,430	128,444	139,622

Ohio Physicians Surgeons Medical Malpractice Rates Selected Specialties by County as of

November 01, 2005

Fully Mature Claims Made Policy, \$1M / \$3M limits

OB/GYN

Company & Effective Date	Medical Protection	Medical Assurance	OHIC 6/1/05	American Physicians Assurance		The Doctors Company 1/1/04
				11/1/05	566	
Class Code	7	80153	80153	7		
County		13				
1 Adams	102,419	69,642	85,364	71,403	89,806	
2 Allen	102,419	92,389	85,364	105,782	93,725	
3 Ashland	102,419	92,389	85,364	105,782	93,725	
4 Ashtabula	153,635	124,234	119,509	190,407	110,768	
5 Athens	102,419	92,389	85,364	105,782	93,725	
6 Auglaize	102,419	92,389	85,364	105,782	93,725	
7 Belmont	107,548	106,037	85,364	116,360	93,725	
8 Brown	81,938	69,642	85,364	71,403	89,806	
9 Butler	81,938	69,642	106,705	71,403	69,806	
10 Carroll	102,419	92,389	85,364	105,782	93,725	
11 Champaign	102,419	69,642	85,364	86,741	89,806	
12 Clark	102,419	69,642	85,364	86,741	89,806	
13 Clermont	81,938	69,642	85,364	71,403	89,806	
14 Clinton	81,938	69,642	85,364	71,403	89,806	
15 Columbiana	107,548	106,037	119,509	116,360	110,768	
16 Coshocton	102,419	92,389	85,364	105,782	93,725	
17 Crawford	102,419	92,389	85,364	105,782	93,725	
18 Cuyahoga	153,635	133,333	119,509	211,563	123,070	
19 Darke	81,938	69,642	85,364	86,741	89,806	
20 DeLancey	102,419	92,389	85,364	105,782	93,725	
21 Delaware	102,419	92,389	85,364	105,782	93,725	
22 Erie	153,635	92,389	85,364	105,782	93,725	
23 Fairfield	107,548	92,389	85,364	105,782	93,725	
24 Fayette	107,548	92,389	85,364	105,782	93,725	
25 Franklin	107,548	92,389	85,364	105,782	93,725	
26 Fulton	102,419	92,389	85,364	105,782	93,725	
27 Gallia	102,419	92,389	85,364	105,782	93,725	
28 Geauga	153,635	124,234	119,509	190,407	110,768	
29 Greene	81,938	69,642	85,364	86,741	89,806	
30 Guernsey	102,419	92,389	85,364	105,782	93,725	
31 Hamilton	81,938	69,642	78,827	71,403	89,806	
32 Hancock	102,419	92,389	85,364	105,782	93,725	
33 Hardin	102,419	92,389	85,364	105,782	93,725	
34 Harrison	102,419	92,389	85,364	105,782	93,725	
35 Henry	102,419	92,389	85,364	105,782	93,725	
36 Highland	102,419	69,642	85,364	71,403	89,806	
37 Hocking	102,419	92,389	85,364	105,782	93,725	
38 Holmes	102,419	92,389	85,364	105,782	93,725	
39 Huron	102,419	92,389	85,364	105,782	93,725	
40 Jackson	102,419	69,642	85,364	116,360	93,725	
41 Jefferson	107,548	106,037	85,364	116,360	93,725	
42 Knox	102,419	92,389	85,364	105,782	93,725	
43 Lake	153,635	124,234	119,509	190,407	110,768	
44 Lawrence	102,419	69,642	85,364	71,403	89,806	
45 Licking	107,548	92,389	85,364	105,782	93,725	
46 Logan	102,419	92,389	85,364	105,782	93,725	
47 Lorain	153,635	133,333	119,509	211,563	123,070	
48 Lucas	102,419	92,389	85,364	105,782	93,725	
49 Madison	102,419	92,389	85,364	105,782	93,725	
50 Mahoning	153,635	124,234	119,509	190,407	123,070	
51 Marion	102,419	92,389	85,364	105,782	93,725	
52 Medina	153,635	110,586	119,509	121,649	110,768	
53 Meigs	102,419	92,389	85,364	105,782	93,725	
54 Mercer	102,419	92,389	85,364	105,782	93,725	
55 Miami	81,938	69,642	85,364	86,741	89,806	
56 Monroe	107,548	106,037	85,364	116,360	93,725	
57 Montgomery	81,938	69,642	85,364	86,741	89,806	

Ohio Physicians Surgeons Medical Malpractice Rates Selected Specialties by County as of

November 01, 2005

Fully Mature Claims Made Policy, \$1M / \$3M limits

OH/GVN

Company & Effective Date Class Code	Medical Protective 6/1/05	Medical Assurance 5/1/05	OHIC 6/1/05	American	
				Physicians Assurance 11/1/05	The Doctors Company 11/1/04
Classification	7	13	80153	7	566
County					
58 Morgan	102,419	92,389	85,364	105,782	93,725
59 Morrow	102,419	92,389	85,364	105,782	93,725
60 Muehleberg	102,419	92,389	85,364	105,782	93,725
61 Nobbs	102,419	92,389	85,364	105,782	93,725
62 Ottawa	102,419	92,389	85,364	105,782	93,725
63 Paulding	102,419	92,389	85,364	105,782	93,725
64 Perry	102,419	92,389	85,364	105,782	93,725
65 Pickaway	102,419	92,389	85,364	105,782	93,725
66 Pike	102,419	92,389	85,364	105,782	93,725
67 Portage	153,635	124,234	119,509	190,407	123,070
68 Preble	81,938	69,642	65,364	85,741	69,806
69 Putnam	102,419	92,389	85,364	105,782	93,725
70 Richland	102,419	92,389	85,364	105,782	93,725
71 Ross	102,419	92,389	85,364	105,782	93,725
72 Sandusky	102,419	92,389	85,364	105,782	93,725
73 Schoo	102,419	92,389	85,364	105,782	93,725
74 Seneca	102,419	92,389	85,364	105,782	93,725
75 Shelby	153,635	110,586	119,509	121,649	94,725
76 Stark	153,635	110,586	119,509	121,649	110,768
77 Summit	153,635	124,234	119,509	190,407	123,070
78 Tunkhull	102,419	92,389	85,364	105,782	93,725
79 Tuscarawas	102,419	92,389	85,364	105,782	93,725
80 Union	102,419	92,389	85,364	105,782	93,725
81 Van Wert	102,419	92,389	85,364	105,782	93,725
82 Vinton	102,419	92,389	85,364	105,782	93,725
83 Warren	81,938	69,642	65,364	71,403	69,806
84 Washington	107,548	106,037	85,364	116,360	93,725
85 Wayne	153,635	92,389	119,509	105,782	93,725
86 Williams	102,419	92,389	85,364	105,782	93,725
87 Wood	102,419	92,389	85,364	105,782	93,725
88 Wyandot	102,419	92,389	85,364	105,782	93,725

**Ohio Medical Liability Insurance
Premium, Losses, and Cost of Investigation and Defense
Top Five Insurers**

	Premiums Earned	Costs for Payments to Claimants	Costs for Investigation and Defense	Costs for Claim Payments plus Investigation and Defense	Ratio of Total Claim Costs to Premium
Medical Protective Company					
2001	53,637,444	44,102,378	13,308,590	57,408,968	107.0%
2002	69,998,445	54,323,019	9,348,900	63,669,919	91.0%
2003	109,951,559	94,669,904	29,542,203	124,211,007	113.0%
3 Years	233,587,448	193,094,201	52,195,693	245,289,894	105.0%
Medical Assurance Company (including ProNational)					
2001	49,819,451	39,905,157	24,133,954	64,039,111	128.5%
2002	64,380,821	63,185,915	22,051,469	85,247,384	132.4%
2003	95,512,583	62,912,480	30,765,140	92,777,630	97.1%
3 Years	209,712,855	165,113,562	76,950,563	242,064,125	115.4%
OHIC Insurance Company					
2001	51,050,336	26,303,775	15,561,458	41,865,233	82.0%
2002	89,601,413	100,302,134	34,970,755	135,272,889	154.4%
2003	83,443,882	78,734,202	14,207,068	92,941,270	111.4%
3 Years	204,095,631	205,340,111	64,739,281	270,079,392	132.3%
American Physicians Assurance Corp.					
2001	19,817,813	48,230,911	13,959,104	60,190,015	303.7%
2002	29,328,053	42,860,164	7,003,599	49,863,763	170.0%
2003	30,978,017	35,101,039	10,872,776	45,973,815	148.4%
3 Years	80,123,883	124,192,114	31,835,479	156,027,593	194.7%
The Doctors Company - An Interinsurance Exchange					
2001	13,282,963	14,616,068	3,469,703	17,994,761	135.4%
2002	15,449,785	12,619,417	3,285,689	16,105,106	104.2%
2003	27,935,354	20,683,961	1,715,904	22,409,865	80.2%
3 Years	56,668,092	48,028,436	8,471,296	56,499,732	99.7%
Total for Top Five Companies					
2001	187,607,797	171,057,279	70,430,809	241,488,068	128.7%
2002	248,758,617	273,500,649	78,658,412	350,159,061	140.8%
2003	347,821,395	291,210,496	87,103,091	378,313,587	108.8%
3 Years	784,187,709	735,768,424	234,192,312	969,960,736	123.7%

- Notes:**
1. These costs do not include expenses for company operations, in-house claims staff, commissions, and taxes paid to states, which represent an additional 25% of premium.
 2. Cost of Payments to Claimants is known as Incurred Losses. It includes amounts paid during the year, reserves for claims that occurred during the year, and adjustments to reserves for claims from previous years.
 3. Investigation and Defense costs are known as Incurred Defense and Cost Containment Expenses. They include amounts paid to defend policyholders, reserves for defense costs for claims that occurred during the year, and adjustments to reserves for defense costs for claims from previous years.
 4. All figures are on a direct basis. I.e., they do not include reinsurance transactions.

Source: Annual Financial Statements, NAIC



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Ohio Department of Insurance Physician Medical Malpractice Insurance Survey

Executive Summary

The rising cost of malpractice insurance has significantly impacted Ohio physician behavior. Nearly 40 percent of the 1,358 respondents to the Ohio Department of Insurance survey said they have retired or plan to retire in the next three years due to rising insurance expenses. Only 9 percent of the respondents were over age 64.

Northwest Ohio can anticipate the highest number of those retirements, with more than 40 percent of the local physicians planning to leave in the next three years.

Ninety-six percent of the respondents had malpractice rate increases in 2004. The average annual premium for personal medical malpractice insurance paid by these Ohio physicians in 2004 was \$40,386, a 38 percent increase compared with 2003 expenses. On average, physician respondents paid 18 percent of their gross annual income in premiums.

Rates for insurance, however, vary from state to state and are very different within each state based on the specialty practice of the physician.

The Ohio Department of Insurance examined the survey of doctors to focus on how professional liability insurance rate increases have changed the way doctors practice medicine in Ohio and to learn doctors' preferences for solutions.

Anecdotal evidence has been presented in Ohio and across the country that a crisis has been developing due to the rapid premium increases. This study quantified the impact on physicians and patients and was large enough to show how Ohioans in different regions of the state and with varying medical needs are being affected.

The rising costs of malpractice insurance have significantly impacted physician behavior and doctors have changed their practices or are planning to do so.

More than 80 percent of the state's neurology and specialty surgeons responding to the survey are planning to retire in the next three years due to their own rate increases. These specialists, along with obstetricians, are considered higher insurance risks and are charged the highest rates among physicians.

Ohio's patient population is steadily being impacted. In addition to the anticipated reduction in the number of physicians, the survey results show there has been a significant reduction in the services offered to Ohio patients. Fifty-six percent of physicians surveyed have turned down or referred high-risk procedures patients elsewhere.

The situation is critical in Southwest Ohio, where 85 percent of the survey respondents have turned down or referred patients who required high-risk procedures to other practitioners.



Accredited by the National Association of Insurance Commissioners (NAIC)
Consumer Hotline 1-800-656-1326 Ethical Hotline 1-800-656-1327 OSHIFP Hotline 1-800-656-1378

Forty-eight percent of OB/Gyn and family practice physicians in Northeast Ohio surveyed have stopped delivering babies due to insurance costs, and more than 50 percent of the osteopathic doctors in the state no longer deliver babies.

Insurance concerns have also affected where physicians will see patients. Physicians responding to the survey have reduced the number of patients they see in nursing homes (55 percent have cut back), home care settings (46 percent have cut back), and hospice settings (30 percent have cut back).

Northeast and Southeast Ohio have been hit particularly hard. Sixty percent of the survey group from Southeast Ohio report having cut their in-home visits, while 54 percent of physicians surveyed in Northeast Ohio say they have cut in-home care.

Physicians recognize a need for patients to have recourse when malpractice occurs. In the survey, they recommend the state of Ohio pursue remedies that focus first on determining the merits of a claim before it is filed in court.

Methodology

- This is the largest study of the impact of malpractice insurance rates conducted to date in the State of Ohio.
- 8,000 surveys were mailed to a random sample of Ohio physicians.
- 1,359 surveys were returned, for a 17 percent response rate.
- Comparisons among physicians' specialties, region of the state, age, and number of liability claims were conducted on every question.

Objectives

- To understand how medical malpractice insurance has impacted Ohio physicians' revenue, as well as physicians' willingness to perform certain procedures, invest in their practices, and continue to practice medicine in Ohio.
- To learn how medical malpractice insurance has impacted overall physician care, patient access to care and the patient experience.
- To determine physician interest in various proposed measures to stabilize medical malpractice insurance premiums.

Conclusions

1. The first conclusion is that the rising costs of malpractice insurance have significantly impacted physician behavior and doctors have closed or are planning to close their practices.

- We learned that nearly four out of 10 respondents said they have retired or plan to retire in the next three years due to rising insurance expenses. This finding is all the more sobering since just 9% of the respondents were over age 64.
- More specifically:
 - The percentage of doctor retirements is even higher in Northeast Ohio.
 - More than half of Ohio's neurologists and specialty surgeons responding to the survey plan to retire because of malpractice insurance rates. These specialties, along with obstetrics, are considered higher insurance risks and are charged the highest rates.

2. Second, rising premiums and the exodus of doctors have already negatively affected Ohio's patient population. In fact, a significant reduction in patient services has already occurred.

- For example, 66% of physicians surveyed have turned down or referred high-risk procedure patients elsewhere.
 - The situation is critical in Southeast Ohio, where 95% of physicians surveyed have declined or referred high-risk patients.
 - In addition, 48% of OB/GYN and family practice physicians in Northeast Ohio reported they have stopped delivering babies due to insurance costs.
 - Over half of Ohio's osteopathic doctors reported they no longer do deliveries.
- Also, high malpractice insurance premiums have influenced where physicians will see patients. Respondents indicated that
 - 55% have reduced the number of patients they see at nursing homes.
 - 46% have cut back the number of patients they see in home care settings.
 - And 30% see fewer patients in hospice settings.
 - The percentages are particularly high in Northeast and Southeast Ohio.
 - Physicians are minimizing patients in these settings because they consider them high-risk in terms of medical liability.

- Patient care has been impacted in other ways as well:
 - Nearly three-quarters of physician respondents say that they order more tests to better defend their decisions.
 - Physicians also report that they need to see more patients to remain financially viable, which results in longer waits for appointments and less time with each patient.
 - Finally, many doctors have cut their staff in response to malpractice insurance increases.
3. The third conclusion from the survey is that malpractice insurance premiums have risen dramatically and have strained office economies.
- 2004 rates went up for 96% of survey respondents, rising by an average of 39% over 2003. Well over a quarter of Ohio physicians responding paid more than \$50,000.
 - On average, almost 20% of physicians' gross annual income – one dollar in five – goes to pay malpractice premium costs.
 - Rates vary widely, both among states and within medical specialties. In Ohio, for example, OB/GYN physicians responding to the survey pay an average of 30% of their annual incomes – 50% more than the average physician – to malpractice insurers.
4. The survey's final conclusion deals with curative measures, steps we might take to remedy the current problem. Here we found that physicians, while recognizing the need for patient recourse when malpractice occurs, generally favor any proposed measure to address rising medical malpractice insurance costs.
- They are particularly supportive of a Medical Review Panel to screen medical liability cases, prior to court filing, to determine the merits of the cases. Almost nine physicians in 10 [88%] highly favor this proposal.

- **Eighty percent of survey respondents highly favor the institution of a 60-day Mandatory Notice. This would require medical liability insurance companies to notify physicians well in advance if their policy were being cancelled or not renewed, or if they were receiving a significant premium increase. The Department spearheaded legislation (S.B. 187 effective 9/13/04) last year to implement this requirement.**
- **Finally, more than three doctors in four [76%] highly favor what is called Expert Witness Qualification Review. This would require the plaintiff to submit a "certificate of expert review" confirming that each medical expert witness is qualified to serve in that capacity. Legislation (H.B. 215 effective 9/13/04) was passed last year with the Department's sponsorship requiring witnesses to be pre-certified as expert witnesses in their field by the Ohio State Medical Board.**