



Rural **RESEARCH REPORT**

Winter 2005
Volume 16, Issue 2

Published by the Illinois Institute for Rural Affairs

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Western Illinois University
1 University Circle
Macomb, IL 61455-1390
309/298-2237

www.IIRA.org

Are Rural Illinois Doctors Leaving? Views of Rural Health Professionals

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Background and Rationale

The purpose of this paper is to present information on a pilot study of the perceptions of rural healthcare professionals on medical liability insurance and the impact of liability insurance costs on healthcare delivery in rural communities. The issue of medical liability insurance costs has long been a concern to both healthcare providers and policymakers interested in how the U.S. system of medical tort liability affects access to physician services, particularly in regards to low-income and rural populations. Dubay et al. (2001) examined the impact of medical liability pressure (as measured by medical liability premiums) on prenatal care utilization and infant health outcomes. They found that increases in premiums were associated with higher levels of late prenatal care and a lower number of prenatal visits; however, there was no evidence that increased medical liability premiums negatively impacted health status measures.

Access to obstetrical care has been the primary concern of observers of the rising cost of medical liability premiums for physicians providing obstetrical care. A study of 12 nonmetropolitan counties in Arizona revealed that of the approximately 90 surveyed physicians providing obstetrical care, 47.2 percent intended to stop their medical practices within the next two to four years (Burns et al. 1999). With

fewer rural primary care physicians providing obstetrical services, the study expressed a concern for access to health care in rural areas and potential impact on prenatal and birth outcomes. Additionally, the Center for Studying Health System Change (HSC) reported that in response to the threat of litigation and medical liability, physicians referred more patients to emergency departments, safety net hospitals, and academic health centers (Berenson et al. 2003). While HSC researchers found little conclusive evidence that the medical liability insurance climate has seriously lessened access to care, they did find that continuity of care and patient choice had been compromised.

Berenson et al. (2003) reported observing variations in the medical liability insurance climate by geographical location. In northern New Jersey and in Cleveland, they identified physicians who experienced premium increases of over 100 percent on an annual basis. In Greenville, South Carolina; Orange County, California; Boston; Little Rock; Phoenix; and Seattle, annual increases in malpractice insurance premiums averaged 20 to 30 percent. They also noted a lack of professional liability difficulties in Indianapolis, Indiana, which is located in a state with tort law that significantly limits payments to malpractice victims.

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The authors greatly appreciate and acknowledge the eleven administrators and physicians who assisted in data collection, as well as those practitioners who provided valuable insight into the current malpractice situation.

According to the American Medical Association, Illinois is one of 19 states that is in a “full blown” medical liability insurance crisis (“The Doctors Are Leaving” 2004). From 2001 to 2003, medical liability claims in Illinois have jumped 45 percent, with a median payout for a claim increasing from \$230,000 in 1993 to \$520,000 in 2003 (“The Doctors Are Leaving” 2004; Illinois Department of Insurance 2001). As a result, insurance providers are pulling back. Today, there are only four insurance companies offering medical liability insurance policies to physicians practicing in Illinois, compared to 16 companies just three years ago.

The Illinois Department of Insurance (2001) found numerous patterns related to medical liability insurance between the years 1980 and 1999. The findings indicated that several factors may be involved in the recent substantial increases of medical liability premium rates. With regard to geographic location, the proportion of claims paid increased about 5 percent in Region 1 (Cook, Madison, McHenry, St. Clair, and Will Counties).² One measure of medical malpractice litigation experience is the number of malpractice claims that proceed to actual cash payments to the plaintiff. The number of claims with payments increased substantially in all areas of Illinois beginning in 1985. In the years between 1980 and 1984, there were 1,786 claims with payments statewide. That number nearly doubled over the next five years (1985 to 1989) to 3,233 claims with payments. Only a modest increase occurred between 1990 to 1994 when there were 3,400 claims with payments, followed by a decrease to 2,815 claims with payments between 1995 to 1999.

In contrast to the statewide numbers, the claims with payments linked to non-urban residents of Illinois actually decreased over the same time periods. In the years between 1980 and 1984, there were 453 claims with payments. From a high of 759 claims with payments during the years 1985 to 1989, there were 706 claims with payments between 1990 and 1994 and just 671 claims with payments between 1995 and 1999. The percent of the amount of claims paid in non-urban areas remained at about 21 to 23 percent of total state claims between the years 1985 to 1999. The average indemnity of claims—the total amount of dollars of loss settlement paid by the insurance company—paid during this same time period was always at least \$50,000 more in Region 1 than in other areas of the state (Illinois Department of Insurance 2001).

Given the impact and complexity of the issue, there are multiple perspectives on the medical liability insurance crisis, including the views of healthcare providers, insurers,

trial attorneys, and consumers. Therefore, it is not surprising that there are multiple proposed solutions to the problem, including the following:

- Requiring caps on non-economic damages such as pain and suffering
- Monitoring potential profiteering by insurance companies through cost shifting
- Encouraging tort reform
- Mandating quality improvement activities among all healthcare providers and facilities
- Developing innovative healthcare delivery systems that minimize adversarial relationships

The diversity of perspectives in Illinois, as is the case nationally, complicates efforts to identify and implement solutions.

To date, the evidence regarding healthcare professionals’—particularly physicians’—responses to the medical liability insurance crisis (e.g., number of claims filed, number of instances of actual malpractice, and increases in liability insurance premiums) is largely anecdotal. Most often these are case-based descriptions, describing the specific experiences of a single individual. Overall, there is little, if any, direct evidence of the impact of the crisis related to rural healthcare professionals and rural healthcare systems.

Medical malpractice and resulting liability insurance issues are receiving attention not only in the healthcare, legal, and political sectors. Differing views have been discussed and debated in television, radio, and print features in multiple publications such as *Illinois Issues* (April 2004) and the *Chicago Tribune* (April 18, 2004). Further, physicians in Illinois, with the encouragement of the Illinois State Medical Society, are now wearing buttons printed with “Ask me—How does the medical liability crisis affect you?” to promote discussions of the issue with their patients. Clearly, the medical malpractice crisis is a significant healthcare issue with implications for economics, healthcare availability and accessibility, health outcomes, and patient-practitioner relationships.

The pilot study reported here addressed the medical liability insurance situation by collecting empirical evidence on the perspectives of selected rural healthcare professionals. This is particularly important given the potential economic vulnerability of rural communities, populations, and healthcare systems.

² The Illinois Department of Insurance groups counties into regions for reporting purposes. The regions share similar characteristics, although geographically the counties comprising the region may be at opposite ends of the state.

Methodology

To conduct this pilot research, a convenience sample of sentinel rural Illinois hospitals was identified to maximize the inclusion of hospitals from different geographic locations (northern, central, and southern) with various practice arrangements (e.g., solo practice, privately held group practice of primary care physicians, privately held group practice that includes some specialists, practicing primary care physicians employed by hospital or healthcare systems) and differential economic and organizational characteristics (including Critical Access Hospitals, federally qualified health centers, and other private and nonprofit hospital systems). Using these categories, 11 hospitals were identified for this research. At each hospital, a liaison—usually the hospital CEO or administrator, sometimes a physician—was identified and asked to assist with the distribution of the survey instrument. The survey instrument was used rather than phone or face-to-face interviews to provide anonymity in an effort to be as unobtrusive as possible in the data collection.

The survey instrument and methods were approved by the University of Illinois Institutional Review Board. An agreed-upon number of surveys was sent to each hospital liaison for completion by CEOs/administrators and physicians. The number of surveys per study site varied based on hospital staff size. There were no identifiers on the surveys, and a two-week follow-up by the research team was conducted with the hospital liaison, consisting of a phone call/e-mail and possibly a request for additional surveys.

Survey questions focused on the following content areas:

- Perception of whether or not there is a medical liability insurance problem in the community
- Perception of impact of medical liability insurance on practice patterns and the community
- Estimate of increase in medical practice premiums over the past two years
- Proposed solutions and prioritization of impact and order of implementation
- Current involvement in activities/programs to impact the malpractice crisis
- Respondent demographics, including years in practice and medical specialty, if a physician

Additionally, characteristics of the community, such as total population, median household income, poverty rate, and primary industry, were compiled by a research assistant for analysis.

Analysis consisted of a description of the extent to which medical liability insurance is a problem, the types of problems, and the proposed solutions by rural administrators and physicians, using frequency and percent distributions. Additionally, bivariate analysis was conducted to look for patterns in responses as a function of such variables as geographic location; community size; and, for physicians, years of practice in the community.

Results

Forty-six surveys from staff and providers at six rural hospitals were completed and returned. Population of the towns in which the hospitals were located ranged from approximately 3,000 to 16,000, with the median household income ranging from \$22,000 to \$42,000. In five of the six hospital communities, the primary industry was education, health, and social services, with manufacturing the primary industry in the remaining community. Geographically, two of the six hospital communities were in central and northern Illinois and four were in southern Illinois.

Forty-three of the survey respondents indicated their profession: 86 percent were physicians, and 14 percent were hospital administrators. Most responding physicians—59 percent—represented primary care specialties (family medicine, general internal medicine, and pediatrics), 30

percent were in specialty care, and 11 percent did not indicate a specialty.

Sixty percent of the physicians were in a practice arrangement in which they were not employed or owned by a hospital, with 22 percent of these physicians in solo practice. The median number of years in practice in the current community was 13.5.

All survey respondents—physicians and hospital administrators—agreed or strongly agreed that medical malpractice was a concern for them. Sixty-five percent disagreed that medical malpractice is more of an issue in urban than rural areas, with 15 percent reporting a neutral opinion.

Respondents were asked to estimate the percent increase in the practice premium rate for their office, clinic, or hospital over the past two years. Results are presented in Figure 1. A little more than 20 percent of respondents indicated that rates had increased by 25 percent or less. At the other end of the spectrum, 35 percent of respondents stated that rates over the past two years had increased by greater than 50 percent, with 8 percent indicating premium increases of greater than 100 percent.³

When asked their perceptions of the impact the medical liability insurance crisis is having on their rural communities, 78 percent of respondents mentioned that physicians were cutting back on the types of services they offered, and 72 percent additionally indicated that physicians had either moved or planned to move out of their area. Thirty-five percent of the respondents stated that the economic growth of the community was negatively impacted. The following are representative comments made by survey respondents:

“Access to specialties difficult. . . . Physicians retiring or changing jobs”

“Decreasing services provided, [which] results in increase in patient referral”

“Limited OB [obstetric] practice. . . . OB cutting down”

“Loss of neurosurgery/neurologists. . . . Early retirement of primary care physicians”

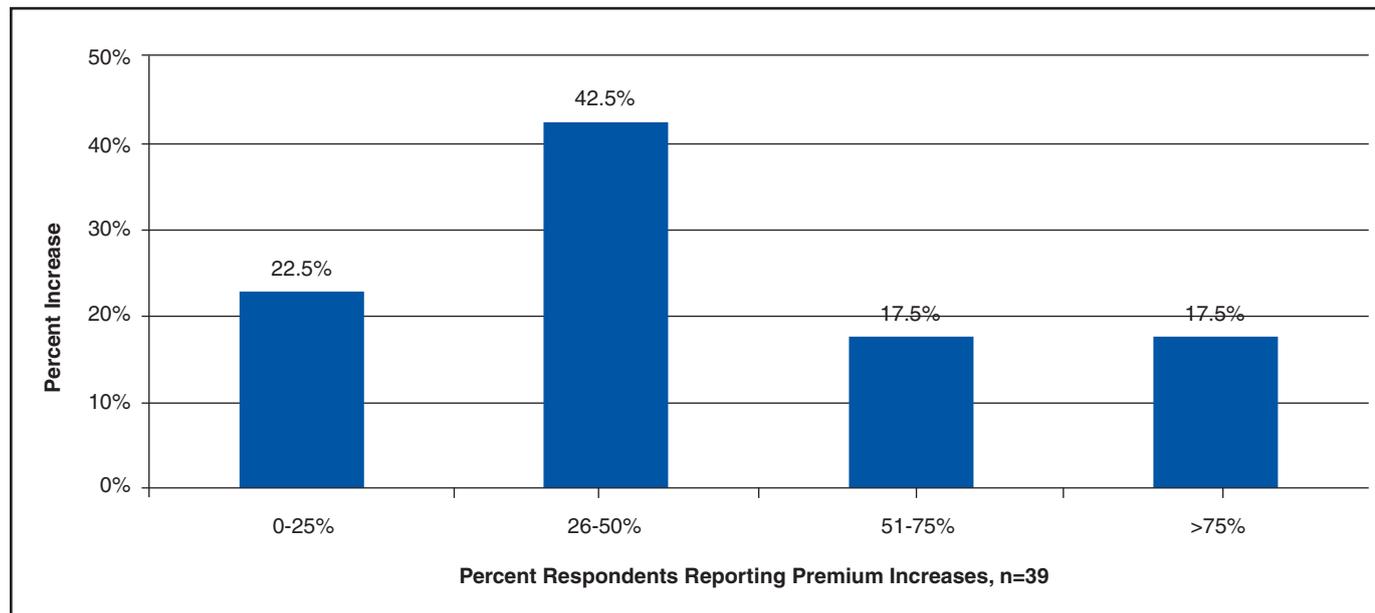
“Family physicians stopping the OB side of practice”

“Physicians are working longer hours and cutting back on types of services”

“Transportation to distant points impossible for many patients”

Respondents were asked to rank order possible solutions from a list of options included in the survey. Results are presented in Figure 2. Most often mentioned by respondents as solutions were State of Illinois setting caps on non-economic damages (93%), limiting attorney contingency fees (88%), setting caps on total damages (74%), and limiting physician liability (62%). Least often mentioned as solutions were the formation of small hospital risk pools (17%) followed by state assistance to meet the costs of liability insurance premiums (26%).

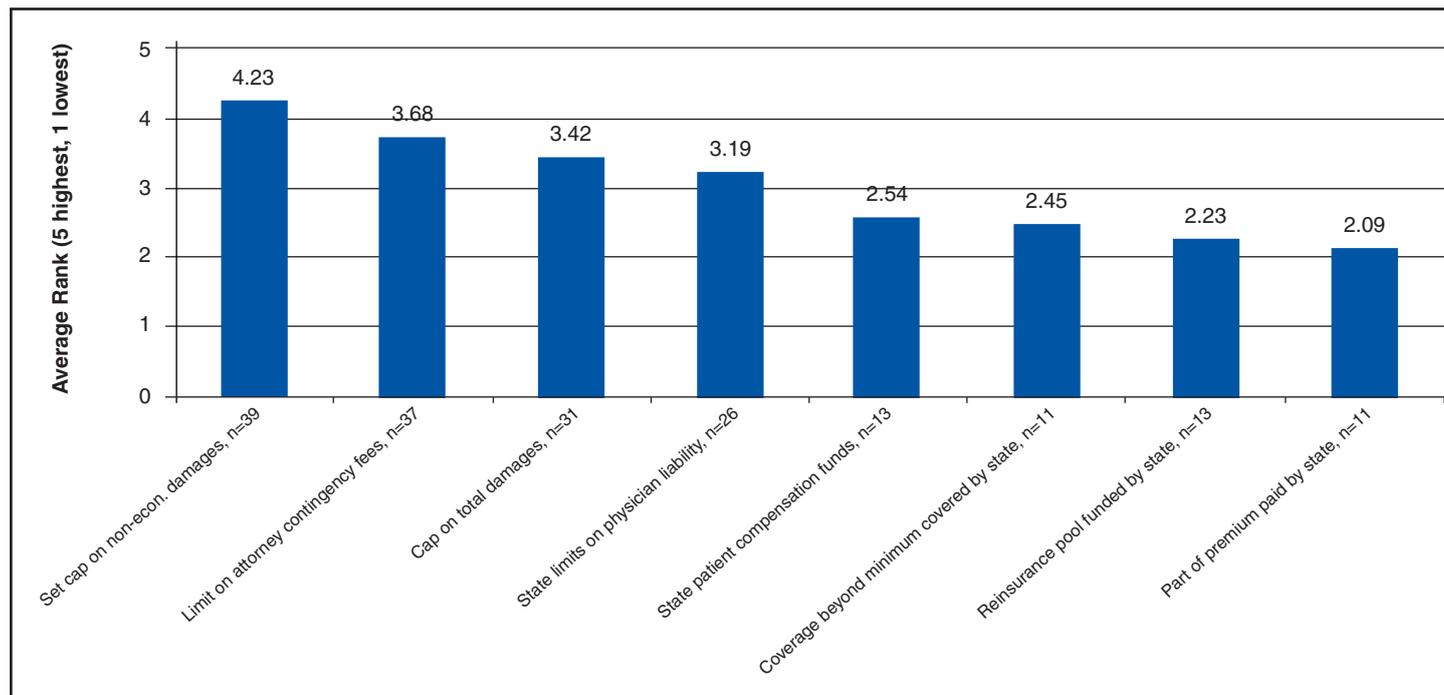
Figure 1. Estimated Percent Increase in the Practice Premium Rate from 2002-2003



Source: Issue of Malpractice in Rural Illinois Survey, Spring 2004.

³ In the present study, there was no differentiation made between providers who have had medical malpractice claims and those who have not had a malpractice claim against them.

Figure 2. Respondents' Ranking of Solutions to the Medical Liability Crisis



Source: Issue of Malpractice in Rural Illinois Survey, Spring 2004.

Given the current attention to medical malpractice and liability in Illinois and nationally, respondents were also asked if they serve on any committees, special groups, or task forces where medical malpractice is a primary issue. Fifteen percent of the responding physicians and administrators indicated “yes.”

There were some patterns in the responses of the physicians and administrators related to geographical location in Illinois (i.e., northern/central compared to southern Illinois communities). As indicated earlier, all survey respondents either agreed or strongly agreed with the statement that medical malpractice was a concern to them; however, respondents from southern Illinois were more likely to strongly agree that malpractice was a concern ($r = .30$; $p = .045$). Southern Illinois respondents also were more likely to state that medical liability premiums resulted in

physicians moving out of the community ($r = .59$; $p < .001$) and that it negatively impacted the economic vitality of the community ($r = .30$; $p = .041$).

Respondents who indicated that medical liability premiums was a concern also were more likely to report this has resulted in physicians moving from the area ($r = .57$; $p < .001$). There was a relationship between the perception that “other health professionals” were leaving the area and that a community was experiencing a decline in economic growth ($r = .33$; $p = .027$). The longer the physicians or hospital administrators had been in the community, the more likely they were to state that their clinic or practice had experienced increased practice premiums ($r = .33$; $p = .041$); physicians were reducing the services they offered ($r = .32$; $p = .048$); and there had been a decline in economic growth ($r = .34$; $p = .038$).

Discussion

This was a pilot study and, therefore, it was limited in scope. The sample size was small, with a targeted number of communities involved; thus, results pertain only to the hospital administrators and physicians participating in the present research. While patterns and themes in responses can be discussed, results are not sufficient to make

generalizations for other rural healthcare professionals and communities.

With the lack of primary data on rural healthcare professionals' responses to medical liabilities cost and the related implications, this research begins to fill this

gap, especially in regards to perspectives and potential impact in rural Illinois. Not surprisingly, survey respondents expressed concern about medical liability and definitely view it as an issue in rural healthcare delivery. Rural professionals indicated that medical liability premiums have resulted or will result in physicians leaving the community, have had an impact on types and volume of services available to rural residents, and have negatively affected the local economy.

The rural healthcare professionals also reported a significant increase in premiums over the last two years. To some degree, it appears that medical liability has a greater perceived negative impact in southern Illinois and in communities with smaller populations. This is possibly due to a lesser number of healthcare professionals in the community and a smaller network of service availability. Years of effort in development of programs and policies to increase the number of healthcare practitioners in rural Illinois appear to be greatly challenged by the perceived medical liability insurance crisis.

When asked about solutions, the rural healthcare professionals overwhelmingly mentioned more “traditional” responses to the crisis (i.e., caps on non-economic damages, limiting contingency fees, and caps on total damages). Options like hospital risk pools and partial

payment of premiums by the State of Illinois were considered less likely alternatives. It would be interesting to compare rural healthcare professionals’ proposed solutions to those of their urban counterparts. A “one size fits all” mentality may not be appropriate to address the medical liability insurance issue in both rural and urban communities. Rural communities may, in fact, be at greater risk due to the vulnerability of their healthcare systems. The loss of one physician or a decrease in physician services in a rural area could place a greater strain on the local healthcare system. This reduction of services could create additional strain on other area healthcare professionals, increasing their workload and decreasing their ability to meet patient demands.

An interesting and unexpected finding was the relationship between attitudes toward the medical liability insurance crisis and the length of time in the community. Healthcare professionals who had been in the rural community longer were somewhat more likely to believe that physician services were being cut back and that the medical liability crisis was contributing to a decline in economic vitality. Perhaps longer-term physicians are more aware of the influence of premiums and rates; on the other hand, these healthcare professionals could be more critical in their assessments than more recently arrived rural healthcare professionals.

Future Directions

If asked whether physicians are leaving rural Illinois as a result of medical liability premium costs, it appears that rural physicians and hospital administrators would resoundingly respond “**yes.**” At least this is the response of a targeted group of healthcare professionals in the six communities surveyed. It is important to continue to examine and understand the attitudes of rural healthcare professionals in regards to the impact of medical liability in their communities. As discussed earlier, the rural response may necessarily be different from the urban. Studies need to be conducted that compare the two. Research also is needed on proposed solutions to this crisis. It would be beneficial to conduct research in rural areas for multiple states to examine differences in state policies and their impact on medical liability rates.

The medical liability insurance situation, as demonstrated in recent budget negotiations in the state legislature, is

something that is not going to go away in Illinois—not without coordinated attempts to address the issue. Sage (2003) argues for the creation of a link between medical liability and patient safety systems, with policymakers exploring enterprise liability or group liability, and where healthcare entities (e.g., systems, practices, hospitals) would have the ability and an incentive to improve patient safety and purchase liability coverage at a reduced cost.

The results of this study, combined with the dearth of rural-specific research, highlight the need for additional rural healthcare research that focuses on the distinct impact of heightened medical liability pressure on access to health care in rural areas.

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