include heart transplantations, but its design was revised to focus on those organs for which there is a greater need. It is hoped that funds will become available to add heart transplantation if the preliminary results are positive.

Progress in the clinical management of HIV infection has been influenced not only by investigators and clinicians, but also by patients and their advocates. Revisiting the policy of excluding HIV-infected persons from consideration for solid-organ transplantation has involved collaboration among clinicians, basic and clinical scientists, patients, and activists. The patient described in the current case report is the senior author of the report and an academician. He is also an activist representing the concerns of people with HIV infection with regard to transplantation. Another patient, who is a prominent playwright and AIDS activist, received a liver transplant because of hepatitis B–induced cirrhosis more than a year ago. In the process, he has become acutely aware of the shortage of organs and is a vocal advocate for increasing the number of organs donated in the United States.

This case report of a heart transplant in an HIV-1–infected recipient who is doing well two years after transplantation, in conjunction with preliminary results from current studies of liver and kidney transplantation, provides hope that selected patients with HIV infection and end-organ failure can benefit from solid-organ transplantation. Bringing the worlds of HIV treatment and transplantation together opens up the possibilities of synergy and progress in important scientific arenas, including immunology and pharmacology; in clinical areas such as the management of peritransplantational hepatitis C; and in public policy. Such progress can benefit all patients who now need or might someday need a transplant and the families and friends who love them.

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The New Medical Malpractice Crisis

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A major medical malpractice crisis is unfolding in the United States today. The American Medical Association has identified 18 states in which physicians and institutional health care providers are having grave difficulties obtaining affordable professional liability insurance. In the past two years, insurance premiums in these states have increased dramatically for physicians in high-risk specialties such as obstetrics, emergency medicine, general surgery, surgical subspecialties, and radiology (see Figure). Another 26 states are on "orange alert," with indicators suggesting a serious and worsening situation. Physicians in West Virginia, New Jersey, Florida, Pennsylvania, Mississippi, Illinois, Texas, and Missouri have held or threatened work stoppages to draw attention to their plight, and several hospitals in the states that have been hit the hardest have temporarily closed or threatened to close emergency room, obstetrical, or other services.

Although alarming to many clinicians and policymakers, today's problems are not new. There have been two other major medical malpractice crises in recent history. The first, in the early to mid-1970s, has generally been described as a crisis of insurance availability. Its distinguishing features were the exit of major malpractice insurers from the market and the inability of many physicians to obtain coverage at any price. This led to the formation in many states of insurance companies owned and operated by physicians ("bedpan mutuals") and state-sponsored joint underwriting associations, many of which still operate today. The second crisis, in the early to mid-1980s, was a crisis of affordability: insurers continued to write policies but charged premiums that many physicians could not afford to pay. Notwithstanding these differences, both previous crises involved a key sequence of events. Physicians in multiple states encountered a sudden spike in mal-

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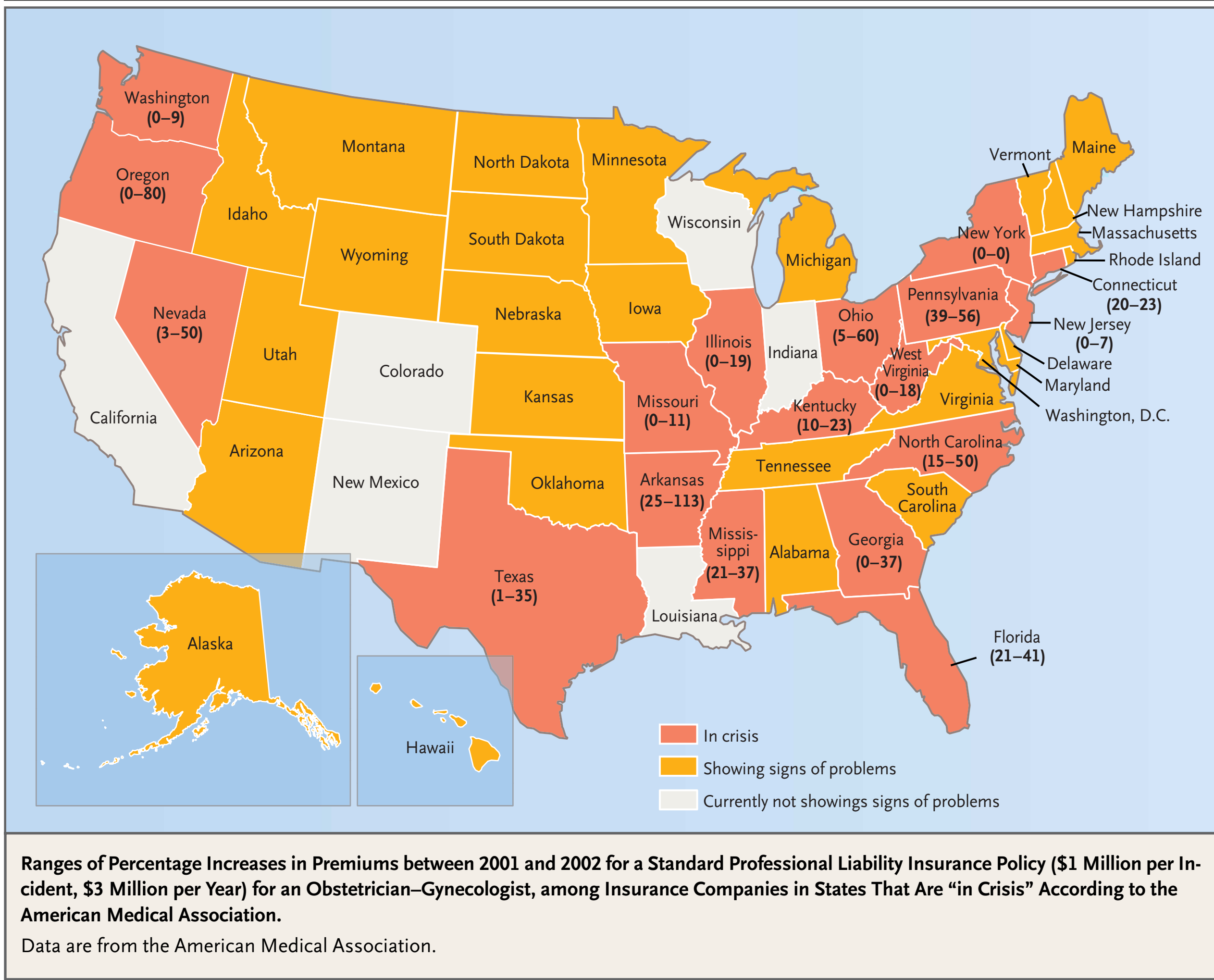

Ranges of Percentage Increases in Premiums between 2001 and 2002 for a Standard Professional Liability Insurance Policy ($1 Million per Incident, $3 Million per Year) for an Obstetrician–Gynecologist, among Insurance Companies in States That Are "in Crisis" According to the American Medical Association.

Data are from the American Medical Association.

practice insurance premiums; difficulties in securing coverage followed, prompting concern about effects on access to certain services such as obstetrical and trauma care.

The current malpractice insurance crisis appears to be one of both availability and affordability. The exit of the St. Paul Companies, the second largest malpractice carrier in the country, from the market in 2001 presaged a more widespread exodus of insurers over the succeeding two years. Many states have seen the departure of carriers that had held a substantial market share, leaving thousands of physicians scrambling to find alternative coverage. In some states, such as Pennsylvania, the remaining insurers have either declined to take new business or have offered coverage only to physicians with an unblemished claims record. Physicians have had to turn to the joint underwriting association in their state as the "insurer of last resort." Although the statutory mission of these organizations is to ensure that all physicians can obtain coverage, the rates charged by these carriers can be prohibitively high, particularly for physicians who have previously been sued. In states such as Florida that do not require physicians to carry liability insurance, a growing number of physicians are "going bare" and not purchasing insurance. "Asset protection" is a growing industry in these jurisdictions, as physicians seek to minimize their exposure to potential losses.

What has brought these troubling times to American medicine? The drivers of the crisis are a subject

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of intense political controversy, and the quantity and the quality of evidence on the issue are thin. The three leading interest groups in the political debate — insurance carriers, health care providers, and trial attorneys — offer competing hypotheses.

According to insurers, the recent hikes in premiums are the direct result of staggering increases in the size (or "severity") of payouts to successful plaintiffs. The largest increases are said to have been in the highest-end awards, but both the median settlement amount and the average administrative cost associated with defending claims appear to have increased substantially.[1] In addition, insurers also cite a small but noticeable increase in the frequency of claims.[1] Insurers blame trial lawyers for stimulating the growth in severity and frequency by aggressively pursuing clients and capitalizing on the recent public concern over medical errors.

Physicians and hospitals join insurers in pointing the finger at the trial bar. They also emphasize the role of a perceived public expectation of perfection in medicine. Citing the weak connection between negligent injuries and malpractice claims, providers argue that the upswing in litigation reflects a public belief that bad outcomes in medicine should not be tolerated and that every injury merits compensation and punishment. They further find fault with "out-of-control juries" who do not understand the realities of medicine or the cumulative effect of multimillion-dollar awards on the cost of health care.

Trial attorneys have responded forcefully with criticism of both health care providers and insurers. To these advocates, invoking the mortality figures associated with medical errors in advertising for attorney services is an entirely legitimate way of alerting the public to the health care system's continuing deficiencies in patient safety, and lawsuits are an important means of motivating providers to practice more safely. When the error rate goes down, they argue, so will litigation rates.

Trial attorneys, joined by some consumer groups, also allege that the recent hikes in premiums are not the result of the increasing severity of claims, but rather the natural consequences of "the insurance cycle." The argument is that insurers irresponsibly underpriced their products in the early 1990s, when competition for market share was fierce and investments of premium dollars in the stock and bond markets yielded impressive returns. Changes over time in the competitiveness of the insurance market, inflation rates, interest rates, stock-market returns, and the cost of reinsurance (occasioned by the attacks of September 11, 2001) then forced substantial increases in premiums, according to this explanation.

An analysis of the evidence behind these competing genesis stories is beyond the scope of this article. However, it is fair to say that each of these drivers has played a part, converging in what commentators have increasingly come to label "the perfect storm." Explanations that pin the current state of affairs on only one or two of these contributing factors are probably off the mark.

Those involved in navigating the way out of this storm face two key questions. First, is the medical malpractice crisis merely a professional crisis, or is it also a crisis in access to care? Groups of health care providers have endeavored to spur political action by demonstrating the effects of the situation on patients. Anecdotal evidence of emergency room closures and expectant mothers' losing their obstetricians is playing powerfully in the policy debate. Unfortunately, there have been no studies yet reported by nonstakeholder organizations regarding the alleged migration of physicians, early retirements, practice restrictions, closures of hospital services, and attendant effects on access to care; nor, remarkably, are such reports available from previous eras. Overall, it appears that hospitals and physician practices are severely strained but still open for business.

The second question is what sort of policy response is needed to resolve the crisis. Proponents of the insurance-cycle hypothesis argue that the problems will be self-correcting. Most health care providers and insurance companies, along with President George W. Bush and Republicans in Congress, advocate caps on damages and other traditional tort reforms. The leading liability-reform bill, the Help Efficient, Accessible, Low-Cost, Timely Healthcare (Health) Act, combines a $250,000 cap on noneconomic ("pain and suffering") damages with several other traditional reforms, such as the elimination of joint and several liability and shorter statutes of limitations, designed to curb the severity of claims and to increase the predictability of payouts.

There is reasonable evidence that some of these measures, most notably damage caps, do reduce payouts,[2,3] albeit at the price of undercompensating the most gravely injured patients. The few well-designed studies that have explored the relation be-

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tween caps and lower insurance premiums are based on data from earlier eras and present mixed findings.[4,5] The effects of caps may not be realized for several years[2]; this reform will not reliably bring immediate relief.

An important shortcoming of traditional tort reform is that it does little to improve the widely recognized deficiencies of the tort system in preventing injuries due to medical errors. Expert committees from the Institute of Medicine and elsewhere are calling for experimentation with more radical reforms, including alternatives to adversarial litigation. For now, however, most expect the malpractice crisis to deepen and spread even in the face of aggressive tort-reform efforts at the state and federal levels.

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