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BRIEFING BOOK

MEDICAL MALPRACTICE: BY THE NUMBERS

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BRIEFING BOOK

MEDICAL MALPRACTICE: BY THE NUMBERS

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PART 1: MEDICAL MALPRACTICE LITIGATION

❖ FEW INJURED PATIENTS FILE CLAIMS OR LAWSUITS; EXPERTS AGREE THAT WHEN CASES ARE FILED, THEY ARE NOT "FRIVOLOUS."

Each year, hundreds of thousands of Americans are killed or injured by avoidable medical errors. [*See* Part 5, "Patient Safety"]. Yet, very few injured patients file claims or lawsuits.

The Medical Malpractice Myth, University of Pennsylvania Law School Professor Tom Baker, 2005.

> "[T]here are far more cases of medical malpractice than medical malpractice litigation. Professor Danzon reported that there were 10 incidents of medical malpractice for every one malpractice claim in the United States. The Harvard group found a seven-to-one ratio in New York and Colorado and a five-to-one ratio in Utah. Because hospital record reviews miss so much medical malpractice, the real multiple is much higher.
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> …
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> "[T]he Harvard team looked at about 30,000 hospital records in New York and found conclusive evidence of a serious injury from medical malpractice in the records of 280 patients. How many of those 280 patients brought a claim? Eight. That is less than 3 percent.
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> "In Utah and Colorado, the team looked at about 15,000 hospital records and found conclusive evidence of a serious injury from medical malpractice in the records of 161 patients. How many of those 161 patients brought a claim? Four. That is also less than 3 percent."[1]

"The Empirical Effects Of Tort Reform," Cornell University Law School Professor Theodore Eisenberg, 2012.

- "One possible factor contributing to the continued high rate of errors is that doctors do not expect to bear the full cost of harms caused by their negligence. Studies of medical error consistently find that the vast majority of patients injured by medical error do not file a claim (Weiler et al. 1993; Sloan et al. 1995; Andrews, 2006). Those that do sue often do not recover. Beyond this, hospitals do not bear the full costs of the harms caused in them even though hospitals directly and indirectly influence patients' risk of medical error (Mello et al. (2007))."[2]

- Experts say that those who try to argue that the system is flooded with frivolous lawsuits deceptively interchange the terms "claims" and "lawsuits" to try to make their case. In other words, "[M]isleading impressions about the medical malpractice system, such as

the AMA's statement that '75 percent of medical liability claims are closed without a payment to the plaintiff' (AMA 2006) depend wholly on failing to distinguish between weak cases, which tend not receive payment, and strong cases, which every study shows to receive payment at a higher rate than that suggested by the AMA. Distinguishing between the two groups of studies is important because a claim presented to an insurer is not the same as a lawsuit. And claims against multiple defendants may lead to recovery from only one, leaving three claims without a payment but an incident with evidence of negligence."[3]

Empirical Studies, National Center for State Courts, 2010, 2011.

In April 2011, the National Center for State Courts (NCSC) found, "despite the widespread prevalence of medical negligence,"[4] medical malpractice case filings "represented well under 2 percent of all incoming civil cases, and less than 8 percent of incoming tort cases"[5] in the general jurisdiction courts of 12 states reporting. As NCSC researchers put it in their 2010 study, "rarely does a medical malpractice caseload exceed a few hundred cases in any one state in one year."[6]

Malpractice Payments Sunk to Record Low in 2011, Public Citizen, 2012.

Public Citizen's most recent analysis of National Practitioner Data Bank (NPDB) data found that there were 3,099 medical malpractice payments for deaths due to negligence in 2011.[7] This means that even if one uses the low end of the IOM estimate — 44,000 deaths per year — about 14 times as many people were likely killed in hospitals in 2011 because of avoidable errors as the number of malpractice payments to survivors.[8] Using a 2009 *Hearst Newspapers* estimate (*i.e.*, 200,000 deaths from medical mistakes per year), just one in 64 deaths was compensated.[9] In other words, between 93 and 98 percent of deaths from medical negligence did not result in any liability payment.

Victor Schwartz, General Counsel, American Tort Reform Association, 2011.

"It is 'rare or unusual' for a plaintiff lawyer to bring a frivolous malpractice suit because they are too expensive to bring."[10]

"Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," Harvard School of Public Health, 2006.

- "[P]ortraits of a malpractice system that is stricken with frivolous litigation are overblown."[11]

- Lead author, David Studdert, Associate Professor of Law and Public Health at HSPH, said, "Some critics have suggested that the malpractice system is inundated with groundless lawsuits, and that whether a plaintiff recovers money is like a random 'lottery,' virtually unrelated to whether the claim has merit. These findings cast doubt on that view by showing that most malpractice claims involve medical error and serious

injury, and that claims with merit are far more likely to be paid than claims without merit."[12]
The authors found:

- Sixty-three percent of the injuries were judged to be the result of error and most of those claims received compensation; on the other hand, most individuals whose claims did not involve errors or injuries received nothing.[13]

- "The profile of non-error claims we observed does not square with the notion of opportunistic trial lawyers pursuing questionable lawsuits in circumstances in which their chances of winning are reasonable and prospective returns in the event of a win are high. Rather, our findings underscore how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information that litigation triggers."[14]

- "Previous research has established that the great majority of patients who sustain a medical injury as a result of negligence do not sue. … [F]ailure to pay claims involving error adds to a larger phenomenon of underpayment generated by the vast number of negligent injuries that never surface as claims."[15]

❖ THE NUMBER ("FREQUENCY") AND SIZE ("SEVERITY") OF MEDICAL MALPRACTICE CLAIMS, LAWSUITS AND INFLATION-ADJUSTED PAYOUTS ARE LOW AND DROPPING.

Empirical Studies, National Center For State Courts/U.S. Department Of Justice, 2007, 2011.

- In an October 2011 study, NCSC researchers found that from 2000 to 2009, med mal filings fell by 18 percent in the general jurisdiction courts of seven states reporting.[16] In five of those states, filings fell by between 18 and 42 percent.[17] These findings are consistent with NCSC's April 2011 med mal report which concluded that "[c]ontrary to the claims of some tort reform advocates, medical malpractice caseloads have been decreasing over time."[18]

- According to DOJ's most recent report on medical malpractice insurance claims in seven states from 2000 through 2004, most claims were closed without any compensation provided to those claiming a medical injury.[19]

True Risk: Medical Liability, Malpractice Insurance And Health Care, Americans for Insurance Reform, 2009.

Medical malpractice claims, inflation-adjusted, are dropping like a rock, down 45 percent since 2000, according to the insurance industry's own data. Inflation-adjusted per doctor claims dropped since 2002 from $8,676.21 that year to $5,217.49 in 2007 to $4,896.05 in 2008.[20] In fact, at no time during the last decade did claims spike or "explode." As A.M. Best put it, "Overall, the most significant trend in [medical professional liability insurance] results over the five years through 2008 is the ongoing downward slope in the frequency of claims.…"[21]

Malpractice Payments Sunk to Record Low in 2011, Public Citizen, 2012.

- "The number of medical malpractice payments made on behalf of physicians fell for the eighth consecutive year in 2011, plummeting to the lowest total since the creation of the National Practitioner Data Bank (NPDB), which has tracked medical malpractice payments since the fall of 1990."[22] Moreover, the "number of payments in 2011 was 41.1 percent lower than in 2000, the year in which the most medical malpractice payments were made. The per capita number of payments in 2011 was 46.1 percent lower than in 2000."[23]

- In its NPDB study, Public Citizen found that the "cumulative value of malpractice payments in 2011 was the lowest in the history of the NPDB if adjusted for inflation by either the consumer price index (CPI) or the medical services index. Even in unadjusted

dollars, payments fell for the eighth straight year in 2011 and were at their lowest level since 1998."[24]

❖ A SMALL NUMBER OF DOCTORS ARE RESPONSIBLE FOR MOST MALPRACTICE PAYOUTS; EVEN THE MOST INCOMPETENT PHYSICIANS ARE RARELY HELD ACCOUNTABLE BY STATE MEDICAL BOARDS.

The Great Medical Malpractice Hoax: NPDB Data Continue to Show Medical Liability System Produces Rational Outcomes, Public Citizen, 2007.

- According to Public Citizen's 2007 analysis of National Practitioner Data Bank (NPDB) files:
    - "The vast majority of doctors – 82 percent – have never had a medical malpractice payment since the NPDB was created in 1990."[25]
    - "Just 5.9 percent of doctors have been responsible for 57.8 percent of all malpractice payments since 1991, according to data from September 1990 through 2005. Each of these doctors made at least two payments."[26]
    - "Just 2.3 percent of doctors, having three or more malpractice payments, were responsible for 32.8 percent of all payments."[27]
    - "Only 1.1 percent of doctors, having four or more malpractice payments, were responsible for 20.2 percent of all payments."[28]
- However,
    - "Only 8.61 percent of doctors who made two or more malpractice payments were disciplined by their state board."[29]
    - "Only 11.71 percent of doctors who made three or more malpractice payments were disciplined by their state board."[30]
    - "Only 14.75 percent of doctors who made four or more malpractice payments were disciplined by their state board."[31]
    - **"Only 33.26 percent of doctors who made 10 or more malpractice payments were disciplined by their state board** – meaning two-thirds of doctors in this group of egregious repeat offenders were not disciplined at all."[32]

State Medical Boards Fail to Discipline Doctors With Hospital Actions Against Them, Public Citizen, 2011.

A March 2011 Public Citizen analysis of National Practitioner Data Bank data shows that "[s]tate medical boards have failed to discipline 55 percent of the nation's doctors who either lost their clinical privileges or had them restricted by the hospitals where they worked." According to the study, given that a physician must exhibit serious deviations

of behavior or performance to warrant hospital disciplinary action (*e.g.*, incompetence, negligence, malpractice, immediate threat to health or safety), the failure of state medical boards to take subsequent action has serious public safety implications. "One of two things is happening, and either is alarming," said Dr. Sidney Wolfe, director of Public Citizen's Health Research Group and overseer of the study. "Either state medical boards are receiving this disturbing information from hospitals but not acting upon it, or much less likely, they are not receiving the information at all. Something is broken and needs to be fixed."[33]

❖ ”TORT REFORMS” KEEP LEGITIMATE CASES FROM BEING FILED.

“Justice In Crisis: Victim Access to the American Medical Liability System,” Emory University Associate Law Professor Joanna Shepherd, 2012.

After conducting a national survey of attorneys, exploring medical malpractice victims’ access to the civil justice system, Shepherd found:

- “As a result of the high costs of medical malpractice investigation and litigation, many malpractice victims are left without legal remedy. These problems are exacerbated by damage caps and other tort reforms that artificially reduce plaintiffs’ damages. Because the cost of trying cases remains the same as before tort reform, but the damages – and in turn, the contingency lawyer’s expected recovery – declines, fewer cases will make economic sense for the lawyer to accept.”[34]

- “[M]y survey provides evidence confirming that many legitimate victims of medical malpractice have no meaningful access to the civil justice system. Because these victims are unable to find legal representation, the injuries they suffer from medical negligence go uncompensated. The lack of victim compensation, in turn, reduces the deterrent effect of the medical malpractice system by blunting incentives for the medical community to improve care that the threat of a suit might otherwise provide.”[35]

❖ PHYSICIANS GREATLY MISPERCEIVE THEIR RISK OF BEING SUED.

"Physicians' Fears Of Malpractice Lawsuits Are Not Assuaged By Tort Reforms," *Health Affairs*, 2010.

> Doctors' fear of lawsuits is "out of proportion to the actual risk of being sued" and enacting "tort reforms" have no impact on this phenomenon, according to an article in the September 2010 edition of *Health Affairs* by David Katz, M.D., Associate Professor of Medicine with University of Iowa Health Care (and several other authors).[36] Several explanations are suggested for this undue fear. One squarely blames the medical societies, which continuously hype the risk of lawsuits to generate a lobbying force to help them advocate for doctors' liability limits. A second possible explanation is that doctors will "exaggerate their concern about being sued, using it as a justification for high-spending behavior that is rewarded by fee-for-service payment systems." A third explanation relates to well-documented human tendencies to overestimate the risk of unfamiliar and uncommon events, such as a fear of plane crashes compared to much more common car crashes. They write, "Lawsuits are rare events in a physician's career, but physicians tend to overestimate the likelihood of experiencing them."

"The Empirical Effects Of Tort Reform," Cornell University Law School Professor Theodore Eisenberg, 2012.

> "A bizarre aspect of the medical malpractice reform debate is the recognition that doctors grossly misperceive the system, accompanied by recommendations to change the system to cater to their misimpressions. Rather than educate doctors about reality, one reads of proposals to change the system to cater to physicians' misperceptions (Hermer and Brody 2010). It seems preferable to include a reasonable medical education requirement focusing on how the legal system operates in medical malpractice cases rather than to curtail the current liability system that is widely recognized as underenforcing standard-of-care norms."[37]

❖ SUCCESSFUL PLAINTIFFS RECEIVE FAR LESS THAN MOST PEOPLE THINK – COMPENSATION IS FOR SERIOUS INJURIES OR DEATH; HIGH VERDICTS ARE ALMOST ALWAYS SLASHED; AND PUNITIVE DAMAGES ARE EXTREMELY RARE.

Empirical Studies, National Center For State Courts/U.S. Department Of Justice, 2009, 2011.

- According to NCSC, in 2005, death was by far the most frequent type of injury among successful medical malpractice plaintiffs, accounting for 22 percent of med mal victims who prevailed at trial.[38] "[I]n the paralysis/amputation category, 100 percent of medical malpractice cases in which the plaintiff received an award involved paralysis caused by injury to the spine or brain…In the brain/head injury category, all injuries alleged by successful medical malpractice claimants were permanent…For burns, lacerations, skin infections, and other skin injuries, all winning medical malpractice patients suffered permanent injuries…."[39]

- In 2005, the latest year studied by DOJ, the median award for successful medical malpractice plaintiffs in state court was $400,000.[40] The median med mal award in jury-decided cases was also $400,000.[41] In contrast, state judges handed down a significantly higher median damage award to medical malpractice victims, $631,000.[42] It is important to note that these median amounts do not account for post-trial activity (such as award modifications) and appeals.[43] NCSC explained that "[t]he larger damage awards in medical malpractice cases do not necessarily imply that juries are acting irrationally or being overly generous to medical malpractice plaintiffs. First, damage awards in medical malpractice cases are generally proportionate to the severity of the injury. Second, the high cost of pursuing a medical malpractice claim means that only those cases in which the plaintiff's injury is severe and the potential damages very large are likely to make it to trial. Because other types of tort cases are less costly to litigate, lower-value cases of these types are more likely to be filed and taken to trial than are low-value medical malpractice cases."[44]

- In 2005, the most recent year studied by DOJ, punitive damages were awarded in only 1 percent of medical malpractice cases where victims established liability at trial.[45] Long-term data from the nation's 75 most populous counties show that the percentage of successful medical malpractice plaintiffs receiving punitive damages is consistently low — 1.1 percent in 1996, 4.9 percent in 2001 and 2.6 percent in 2005.[46]

- After examining the most recent DOJ data available, NCSC researchers found that "[t]he most serious injuries, such as paralysis and cancer, received the largest awards. Consistent with other research, in medical malpractice cases death tended to be compensated somewhat less highly than some other serious injuries such as paralysis, in part because these injuries often require costly lifelong care. Less serious injuries, such as fractures and dental injuries, received smaller awards."[47]

"The Empirical Effects Of Tort Reform," Cornell University Law School Professor Theodore Eisenberg, 2012.

> "The effect of caps and other reforms may help explain increasing awards in medical malpractice cases that reach trial. The number of lawsuits decreases, as suggested by NCSC filing data, but caps require attorneys to be more selective about the cases they accept. …This greater selectivity and need for greater damages to accept a case likely contribute to the increasing observed mean and median medical malpractice awards in cases that do reach trial. Garber et al. (2009) used a survey of 965 plaintiffs' attorneys to assess whether noneconomic damages caps and attorney fee limits affected access to justice for medical malpractice victims. They concluded that caps and fee limits make it harder to retain counsel."[48]

Congressional Testimony, Duke University Law Professor Neil Vidmar, 2006.

> Professor Vidmar told Congress in June 2006, "[T]he magnitude of jury awards in medical malpractice tort cases positively correlated with the severity of the plaintiffs' injuries, except that injuries resulting in death tended to result in awards substantially lower than injuries resulting in severe permanent injury, such as quadriplegia. I and two colleagues conducted a study of malpractice verdicts in New York, Florida, and California. We also found that jury awards of prevailing plaintiffs in malpractice cases were correlated with the severity of the injury."[49]

Malpractice Payments Sunk to Record Low in 2011, Public Citizen, 2012.

> Public Citizen's most recent analysis of National Practitioner Data Bank (NPDB) data shows that the overwhelming majority of medical malpractice payments compensate for death, catastrophic harms or serious permanent injuries.[50] "Of the 9,758 medical malpractice payments in 2011, more than three-fifths (61.4 percent) compensated for negligence that resulted in a significant permanent injury, major permanent injury, quadriplegia, brain damage, the need for lifelong care, or death."[51] More important, the "dollar value of payments for these extremely serious outcomes accounted for four-fifths (80 percent) of the total value of malpractice payments last year. Nearly half the money paid (44 percent) compensated victims and victims' survivors for negligence resulting in death, quadriplegia, brain damage or injuries requiring lifelong care."[52]

"Do Defendants Pay What Juries Award? Post-Verdict Haircuts in Texas Medical Malpractice Cases, 1988–2003," University of Illinois Professor of Law and Medicine David A. Hyman et al., 2007.

> Research by Hyman and colleagues from the University of Texas, New York University Law School and Georgetown University Law Center shows that most med mal jury awards receive post-verdict "haircuts."[53]

According to the Texas data:

- "Seventy-five percent of plaintiffs received a payout less than the adjusted verdict (jury verdict plus pre-judgment and post-judgment interest), 20 percent received the adjusted verdict (within ± 2 percent), and 5 percent received more than the adjusted verdict."[54]

- "Overall, plaintiffs received a mean (median) per-case haircut of 29 percent (19 percent), and an aggregate haircut of 56 percent, relative to the adjusted verdict."[55]

- "The larger the verdict, the more likely and larger the haircut. For cases with a positive adjusted verdict under $100,000, 47 percent of plaintiffs received a haircut, with a mean (median) per-case haircut of 8 percent (2 percent). For cases with an adjusted verdict larger than $2.5 million, 98 percent of plaintiffs received a haircut with a mean (median) per-case haircut of 56 percent (61 percent)."[56]

- "Insurance policy limits are the most important factor explaining haircuts."[57]

- "Most cases settle, presumably in the shadow of the outcome if the case were to be tried. That outcome is not the jury award, but the actual post-verdict payout. … The parties surely bargain in the shadow of the jury, but in most cases, the terms of the bargain are shaped by the shadow of coverage."[58]

- "Because defendants rarely pay what juries award, jury verdicts alone do not provide a sufficient basis for claims about the performance of the tort system."[59]

"Doctors & Juries," University of Missouri-Columbia Law Professor Philip G. Peters, Jr., 2007.

Professor Peters analyzed three decades of empirical research on jury decision-making and reached the following four conclusions: "First, negligence matters. Weak cases rarely win, close cases do better, and cases with strong evidence of medical negligence fare best. Second, the agreement rate between juries and experts is very high in the class of cases that most worries critics of malpractice litigation, that is, cases with weak evidence of negligence. Juries agree with expert reviewers in eighty to ninety percent of these cases. That is a better agreement rate than physicians typically have with each other. Third, the agreement rate is much lower in cases with strong evidence of negligence. Doctors consistently win about fifty percent of the cases that experts believe the plaintiffs should win. Fourth, the consistently low success rate of malpractice plaintiffs in cases that expert reviewers feel they should win strongly suggests the presence of one or more factors that systematically favor medical defendants in the courtroom, such as better litigation teams or pronounced jury reluctance to find doctors liable. From the perspective of defendants at least, jury performance is remarkably good."[60]

American Juries: The Verdict and "The Verdict on Juries," Cornell University Law Professor Valerie P. Hans and Duke University Law Professor Neil Vidmar, 2007, 2008, respectively.

- "The fact that the jury verdict is not the end of litigation is often overlooked in discussions of the role of the jury. This is especially true of medical malpractice trials."[61] According to the authors, "Research consistently indicates that outlier verdicts seldom withstand postverdict proceedings. The judge may reduce the award by *remittitur* (the legal term for a reduction), or the case may be appealed to a higher court at which time the award may be reduced. Perhaps most common of all, the plaintiff and the defendant negotiate a posttrial settlement that is less than the jury verdict. Plaintiffs are willing to negotiate lesser amounts," the researchers added, "because they need the money immediately and cannot wait for the years it will take to get the money if the case is appealed. Also, there is a risk that an appeals court will reduce the award or even overturn the verdict."[62] In the end, the plaintiff "negotiates a settlement around the defendant's insurance coverage."[63]

- For example, "[s]ome of the largest medical malpractice awards in New York that made national headlines ultimately resulted in settlements between 5 and 10 percent of the original jury verdict actually being paid."[64] Similarly, "Vidmar's Illinois study found that settlements in his sample of large jury awards averaged only 43 percent of the original verdicts."[65]

- Hans and Vidmar "explored the claims of doctors …about unfair treatment by juries but the empirical evidence does not back them up. The notion of the pro-plaintiff jury is contradicted by many studies that show both actual and mock jurors subject plaintiffs' evidence to strict scrutiny."[66]

- Interviews with North Carolina jurors who decided medical malpractice cases led Professor Vidmar to conclude that "many jurors initially viewed the plaintiffs' claims with great skepticism. Their attitudes were expressed in two main themes. First, they said that too many people want to get something for nothing, a skeptical attitude about claiming… . Second, they expressed the belief that most doctors try to do a good job and should not be blamed for a simple human misjudgment."[67] Vidmar added, "Indeed, these attitudes were even expressed in some of the cases in which jurors decided for the plaintiff. One jury that gave a multimillion-dollar award for a baby with severe brain injuries was very concerned about the possible adverse effect on the doctor's medical practice. This does not mean that in every such case jurors held these views. Sometimes, evidence of the doctor's seemingly careless behavior caused jurors to be angry about what happened. However, even in these latter cases, the interviews indicated that the jurors had initially approached the case with open minds."[68]

❖ MEDICAL MALPRACTICE CASES ARE NOT CLOGGING THE COURTS; STRONG CASES SETTLE.

Empirical Studies, U.S. Department of Justice, 2009.

In 2005, the most recent year studied by the U.S. Department of Justice (DOJ), only 7.8 percent of medical malpractice cases were disposed of by bench or jury trial in 49 jurisdictions reporting.[69] Between 1996 and 2005, the number of medical malpractice trials concluded in state courts in the nation's 75 most populous counties remained low and fairly stable, increasing by only 1.5 percent over the ten-year period.[70] In 2005, medical malpractice cases accounted for only 9.1 percent of all *civil* cases disposed of by trial in state courts.[71] After examining long-term data, DOJ found that the number of med mal cases as a percentage of all *civil* trials in the nation's 75 most populous counties remained low and relatively steady over a 14-year period, with med mal cases constituting 9.7 percent of all civil trials in 2001 and 11.3 percent of all civil trials in 2005.[72] DOJ data show that in 2005 medical malpractice cases accounted for 14.9 percent of *tort* cases disposed of by trial in state courts nationwide.[73] Long-term data from the nation's 75 most populous counties show that the number of medical malpractice cases as a percentage of all *tort* trials remained low and fairly stable from 1996 through 2005, increasing by only 2.8 percent between 2001 and 2005.[74]

"Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," Harvard School of Public Health, 2006.

The closed claims study found that only 15 percent of claims were decided by trial verdict.[75] Other research shows that 90 percent of cases are settled without jury trial, with some estimates indicating that the figure is as high as 97 percent.[76]

Congressional Testimony, Duke University Law Professor Neil Vidmar, 2006.

Vidmar testified before the U.S. Senate, "Research on why insurers actually settle cases indicates that the driving force in most instances is whether the insurance company and their lawyers conclude, on the basis of their own internal review, that the medical provider was negligent…..An earlier study by Rosenblatt and Hurst examined 54 obstetric malpractice claims for negligence. For cases in which settlement payments were made there was general consensus among insurance company staff, medical experts and defense attorneys that some lapse in the standard of care had occurred. No payments were made in the cases in which these various reviewers decided there was no lapse in the standard of care."[77]

Vidmar added, "In interviews with liability insurers that I undertook in North Carolina and other states, the most consistent theme from them was: 'We do not settle frivolous cases!' The insurers indicated that there are minor exceptions, but their policy on frivolous cases was based on the belief that if they ever begin to settle cases just to make

them go away, their credibility will be destroyed and this will encourage more litigation."[78]

Vidmar further testified, "Without question the threat of a jury trial is what forces parties to settle cases. The presence of the jury as an ultimate arbiter provides the incentive to settle but the effects are more subtle than just negotiating around a figure. The threat causes defense lawyers and the liability insurers to focus on the acts that led to the claims of negligence."[79]

❖ LAWSUITS FILED FOR MEDICAL NEGLIGENCE ARE NOT FRIVOLOUS, YET IT IS STILL DIFFICULT FOR PATIENTS TO PREVAIL.

Empirical Studies, National Center for State Courts/U.S. Department of Justice, 2009, 2011.

- DOJ found that the plaintiff win rate for medical malpractice was only 23 percent in 2005.[80] Juries decided against medical malpractice plaintiffs more than three-quarters of the time.[81] Injured patients were more successful before judges, winning 50 percent of the time.[82]

- Long-term data from state trials in the nation's 75 most populous counties show statistically significant decreases in win rates among medical malpractice plaintiffs. More specifically, the percentage of successful plaintiffs fell by 17 percent from 1996 to 2005 and by 27.7 percent from 2001 to 2005.[83]

❖ EXPERTS SAY THAT, EVEN WITH ITS PROBLEMS, THE CURRENT MEDICAL MALPRACTICE SYSTEM WORKS.

"Could Mandatory Caps on Medical Malpractice Damages Harm Consumers?" California State University, Northridge Economics Professor and Cato Institute Adjunct Scholar Shirley Svorny, 2011.

In an October 2011 study, Professor Svorny analyzed existing empirical data and found that the medical malpractice system works just as it should. As Svorny explained,

- "The medical malpractice system generally awards damages to victims of negligence and fails to reward meritless claims. Plaintiffs' attorneys, paid on a contingency basis, filter out weak cases. Patients who file valid claims are likely to collect, generally through out-of-court settlements."[84]
- "The fact that settlement is common suggests courts are providing good signals as to when plaintiffs will prevail. Under these conditions, insurance companies assess the validity of claims and settle valid claims rather than go to court."[85]
- "Critics of the system point to the fact that many initial claims do not involve negligence. This can be explained by patients and their attorneys seeking to gather information about the level of negligence associated with an injury. Once discovery shows a small likelihood of success, many plaintiffs drop their claims."[86]
- "Critics of the medical malpractice system point to its high administrative costs. …Yet, as economist Patricia Danzon observes, the bulk of administrative costs are limited to the small fraction of cases that go to court. Meanwhile, the deterrent effect influences all medical practice."[87]

"Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," Harvard School of Public Health, 2006.

The closed claims study found that legitimate claims are being paid, non-legitimate claims are generally not being paid and "portraits of a malpractice system that is stricken with frivolous litigation are overblown."[88] Among the researchers' more significant findings:

- Sixty-three percent of the injuries were judged to be the result of error and most of those claims received compensation; on the other hand, most individuals whose claims did not involve errors or injuries received nothing.[89]
- Eighty percent of claims involved injuries that caused significant or major disability or death.[90]
- "[D]isputing and paying for errors account for the lion's share of malpractice costs."[91]

❖ THE BEST WAY TO REDUCE MALPRACTICE LITIGATION IS TO REDUCE THE AMOUNT OF MALPRACTICE.

Is Better Patient Safety Associated with Less Malpractice Activity? Evidence from California, Rand Institute for Civil Justice, 2010.

- "Our results showed a highly significant correlation between the frequency of adverse events and malpractice claims: On average, a county that shows a decrease of 10 adverse events in a given year would also see a decrease of 3.7 malpractice claims. Likewise, a county that shows an increase of 10 adverse events in a given year would also see, on average, an increase of 3.7 malpractice claims. According to the statistical analysis, nearly three-fourths of the within-county variation in annual malpractice claims could be accounted for by the changes in patient safety outcomes."[92]

- "We also found that the correlation held true when we conducted similar analyses for medical specialties—specifically, surgeons, nonsurgical physicians, and obstetrician/gynecologists (OB-GYNs). Nearly two-thirds of the variation in malpractice claiming against surgeons and nonsurgeons can be explained by changes in safety. The association is weaker for OB-GYNs, but still significant."[93]

- "These findings are consistent with the basic hypothesis that iatrogenic harms are a precursor to malpractice claims, such that modifying the frequency of medical injuries has an impact on the volume of litigation that spills out of them. Although this is an intuitive relationship, it is not one that has been well validated previously. It suggests that safety interventions that improve patient outcomes have the potential to reduce malpractice claiming, and in turn, malpractice pressure on providers."[94]

- "[N]ew safety interventions potentially can have positive effects on the volume of malpractice litigation — a desirable result to seek out, even beyond the immediate impact of medical injuries avoided."[95]

- "Presumably, the one thing that all parties to the debate can agree on is that reducing malpractice activity by reducing the number of iatrogenic injuries is a good idea. Arguments about the merits of statutory tort intervention will surely continue in the future, but to the extent that improved safety performance can be shown to have a demonstrable impact on malpractice claims, that offers another focal point for policymakers in seeking to address the malpractice crisis. Based on the results of the current study, we would suggest that that focal point may be more immediately relevant than has previously been recognized."[96]

PART 2: MEDICAL MALPRACTICE, HEALTH CARE COSTS AND "DEFENSIVE MEDICINE"

❖ NUMEROUS STUDIES HAVE DEBUNKED THE NOTION THAT HEALTH CARE COSTS CAN BE SAVED BY STRIPPING AWAY PATIENTS' LEGAL RIGHTS; "TORT REFORM" HAS NO IMPACT ON SO-CALLED DEFENSIVE MEDICINE.

"Will Tort Reform Bend the Cost Curve? Evidence from Texas," Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black et al., 2012.

In June 2012, the *Journal of Empirical Legal Studies* published a groundbreaking study, which concluded that limiting injured patients' legal rights will not reduce overall health-care spending.[97] Professor Black and his co-authors – David A. Hyman, University of Illinois College of Law; Myungho Paik, Northwestern University Law School; and Charles Silver, University of Texas Law School – examined Medicare spending after Texas enacted severe "tort reform" in medical malpractice cases, including "caps" on compensation for injured patients, and found no evidence of a decline in health-care utilization. Among the report's key findings:

Texas's "Tort Reforms" Did Not Reduce Health-Care Spending Or Spending Trends.

- "A major exogenous shock to med mal risk from the reforms had no material impact on Medicare spending (in effect, health-care quantity), no matter how we slice the data."[98]

- "We find no evidence that overall health-care spending, physician spending, or imaging and lab spending declined more in counties with higher med mal risk."[99]

- "We also find no overall decline in Texas Medicare spending relative to control states, nor an overall association between spending (or spending trends) and med mal risk."[100]

- "If anything, we find some evidence, well short of definitive, that physician spending rose after reform in larger, high-risk counties."[101]

- "Our data are limited to Medicare, but med mal reform seems even less likely to influence treatment intensity for the privately insured, since most private insurers exercise greater oversight over treatment decisions than does Medicare."[102]

- "The further one gets from the time of reform, the less reliable will be any effort to have confidence in a causal link between tort reform and health-care spending."[103]

Limiting Patients' Rights Will Have Little Impact On Health-Care Spending.

- "Our results, combined with those from other studies, let us place some bounds on the likely impact of tort reform on spending. We believe a 'credible interval' for the most likely effect of major tort reform on health-care spending runs from 0 percent to about a 2 percent decline for states that currently lack caps on non-econ or total damages."[104]

- "Zero to one percent of health-care spending is $0 to $30 billion per year. The upper end of this range is more than small change, but we believe that claims that tort reform can meaningfully bend the health-care cost curve, or save hundreds of billions of dollars in annual spending, are not plausible, based on the available research."[105]

- "Higher spending cannot be ruled out; indeed, our study finds some evidence suggesting higher spending after reform."[106]

There Are Many Reasons Why "Tort Reform" Doesn't Lower Health-Care Spending.

- "One possibility is that there may not be much 'pure' defensive medicine – medical treatments driven solely by liability risk. If liability is only one of a number of factors that influence clinical decisions, even a large reduction in med mal risk might have little impact on health-care spending."[107]

- "Lower med mal risk could lead some doctors to practice less defensive medicine, yet make other doctors more willing to offer aggressive medical treatment that is profitable to the doctor but of doubtful value to the patient."[108]

- "There could be savings in some areas of medical practice (cardiac care, perhaps), yet higher costs in other areas. The physician tendency toward more aggressive treatment as med mal risk declines might be stronger in urban areas, with more sophisticated physicians. This could explain the hints we find of higher physician spending in these areas."[109]

- "[I]f the major, highly publicized Texas reforms, followed by a major drop in insurance premiums, did little to persuade doctors to practice less defensively, it is unclear what would do so, other than complete abolition of med mal liability. To date, no one has proposed going that far."[110]

Countless Explanations Exist As To Why U.S. Health Care Costs Are Out Of Control.

- "One is physician incentives to provide profitable services….A second is a political system that has thus far been unwilling to impose, for the publicly financed portion of health-care spending, the types of limits on spending that are routine in many other countries."[111]

- Moreover, "[p]olitically convenient myths are hard to kill. The myth that defensive medicine is an important driver of health-care costs is convenient to politicians who claim to want to control costs, but are unwilling to take the unpopular (with physicians or the elderly) steps needed to do so. It is convenient for health-care providers, who prefer lower liability risk. It is also convenient for members of the public, who find it easy to blame lawyers and the legal system for problems that have more complex and difficult roots, and call for stronger responses."[112]

"The Empirical Effects of Tort Reform," Cornell University Law School Professor Theodore Eisenberg, 2012.

"Tort reform" provides little in the way of health care savings: "One recent summary concludes that the 'accumulation of recent evidence finding zero or small effects suggests that it is time for policymakers to abandon the hope that tort reform can be a major element in healthcare cost control" (Paik 2012, 175).'"[113]

True Risk: Medical Liability, Malpractice Insurance And Health Care, Americans for Insurance Reform, 2009.

"In over 30 years, medical malpractice premiums and claims have never been greater than 1% of our nation's health care costs."[114]

CBO's Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice ("Tort Reform"), Congressional Budget Office, 2009

The Congressional Budget Office (CBO), in its October 2009 analysis (in the form of a 7-page letter to Senator Orin Hatch),[115] found that even if the country enacted an entire menu of extreme tort restrictions, it could go no farther than to find an extremely small percentage of health care savings, about 0.5%, "far lower than advocates have estimated."[116] This includes even smaller health care savings – "0.3 percent from slightly less utilization of health care services"[117] or "defensive medicine." CBO ignored factors that would not only lower this already small figure but also likely *increase* costs:

- "CBO acknowledged but did not consider in its cost calculations the fact that these kinds of extreme "tort reforms" would weaken the deterrent potential of the tort system, with accompanying increases in cost and physician utilization inherent in caring for newly maimed patients and for care."[118]

- "There will be new burdens on Medicaid because if someone is brain damaged, mutilated or rendered paraplegic as a result of the medical negligence but cannot obtain compensation from the culpable party through the tort system (which is the impact of capping even non-economic damages), he or she may be forced to turn elsewhere for compensation, particularly Medicaid. None of these increased Medicaid costs are considered."[119]

- "Whenever there is a successful medical malpractice lawsuit, Medicare and Medicaid can both claim either liens or subrogation interests in whatever the patient recovers, reimbursing the government for some of the patients' health care expenditures. Without the lawsuit, Medicare and Medicaid will lose funds that the government would otherwise be able to recoup. Again, none of these lost funds are factored in by the CBO."[120]

- "CBO arrived at its numbers by plugging selective studies into CBO's internal econometric models that no one ever sees. When Senator Jay Rockefeller (D-WV) asked CBO for a "complete empirical analysis of the cost savings associated with medical malpractice reforms," CBO's response was another seven-page letter. No empirical analysis, no econometric models and no data were provided."[121]

The Truth About Torts: Defensive Medicine and the Unsupported Case for Medical Malpractice 'Reform,' Center for Progressive Reform, 2012.

"The evidence reveals that 'defensive medicine' is largely a myth, proffered by interests intent on limiting citizen access to the courts for deserving cases, leaving severely injured patients with no other recourse for obtaining the corrective justice they deserve. These changes would limit the deterrent effect of civil litigation and diminish the regulatory backstop that the civil justice system provides to the professional licensing system, leading to more medical errors.

…

"What is perhaps most striking about the CBO letter, though, is the rare departure from years of careful analysis. The CBO's past work found small savings from civil justice restrictions and declared the evidence on 'defensive medicine' to be 'weak or inconclusive" and "at best ambiguous.' Another CBO report, in 2004, described the limits of Kessler and McClellan's 1996 Medicare research by concluding, 'those studies were conducted on a restricted sample of patients, whose treatment and behavior cannot be generalized to the population as a whole.' In fact, just ten months before its letter to Senator Hatch, the CBO concluded that there is insufficient evidence that civil justice restrictions would reduce health care costs. The past work speaks for itself. Little changed in the research on defensive medicine in the years between CBO's prior analyses and its letter to Senator Hatch."[122]

"Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussions," Columbia University Mailman School of Public Health Clinical Professor Fred Hyde, M.D., 2011.[123]

- "'Defensive medicine' by all accounts has become such a myth, a combination of surveys of interested parties and the 'imagination' that those parties are avoiding – or believe they are avoiding – liability through alteration of their medical practices."

- "The cost, if any, of defensive medicine, are trivial, in comparison to the cost of health care."

- Medical liability "acts as a guardian against under treatment, the primary concern which should now be facing policy-makers."

- "If tort reform reduces or even eliminates sanctions associated with negligent care and activity, adverse events themselves may increase, and by a number far greater than .2, .3 or .7% of the American health care bill."

- "The implicit hypothesis would appear to be the following: That, in contravention of good medical judgment, the basic rules of Medicare (payment only for services that are medically necessary), threats of the potential for False Claim Act (prescribing, referring, where medically unnecessary), physicians will, as a group, act in ways which are possibly contrary to the interests of their patients, certainly contrary to reimbursement and related rules, under a theory that excessive or unnecessary prescribing and referring will insulate them from medical liability. There are many more cases concerning incompetence in credentialing and privileging, negligent referral, unnecessary radiation, etc., to provide at least a counter hypothesis."

- "[A]s reaffirmed in the CBO studies, and as reflected in the literature generally, all estimates of the 'indirect' costs of professional liability, including, for example, the cost, if any, of defensive medicine, are trivial, in comparison to the cost of health care. Controversies involving Senators, the CBO in 2009 appear entirely to reflect the difference between .2 and .5% of health costs."

- "The import of the phrase 'defensive medicine' is in its 'political' or strategic use: 'Defensive medicine has mainly been invoked as an argument for tort reform in the years between malpractice crises when other pressures for legal change have ebbed.' The methods used to study the existence, prevalence and impact of defensive medicine have been, primarily, survey of those (practicing physicians) who may be perceived as having a position or stance in the political discussion, in addition to having access to information necessary to answer the questions posed above."

- "Survey-type findings led to a conclusion that defensive medicine was significant among physicians in Pennsylvania who pay the most for liability insurance. In later studies (Mello [footnote omitted]), however, some of the same authors have cast doubt on the survey as an objectively verifiable means of establishing the presence, quantity or scope of defensive medicine."

- "The fee for service system both empowers and encourages physicians to practice very low risk medicine. Health care reform may change financial incentives toward doing fewer rather than more tests and procedures. If that happens, concerns about malpractice liability may act to check potential tendencies to provide too few services."

- "If most claims result from errors, and most errors result in injuries, and most injuries resulting from such errors result in compensation (73%), what is at stake in limiting access to the courts? If access is limited, it would be in recognition that the basic principle of civil justice, having a remedy available to enforce a right, is void."

Defensive Medicine and Medical Malpractice, Office of Technology Assessment, 1994.

The congressional office found that less than 8 percent of all diagnostic procedures were likely to be caused primarily by liability concerns. According to its analysis, most physicians who "order aggressive diagnostic procedures…do so primarily because they believe such procedures are medically indicated, not primarily because of concerns about liability." The effects of "tort reform" on defensive medicine "are likely to be small."[124]

❖ STUDIES ESTABLISHING "DEFENSIVE MEDICINE" DEPEND ALMOST ENTIRELY ON UNTRUSTWORTHY PHYSICIAN SURVEYS, OFTEN CONCEIVED BY LOBBY GROUPS PUSHING "TORT REFORM."

Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care, General Accountability Office, 2003.

The General Accountability Office (GAO) condemned the use of "defensive medicine" physician surveys as being inaccurate and misleading.[125] The GAO also noted that those who produced and cited such surveys "could not provide additional data demonstrating the extent and costs associated with defensive medicine."[126] And, "some officials pointed out that factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures"[127] and "according to some research, managed care provides a financial incentive not to offer treatments that are unlikely to have medical benefit."[128]

"Critique of February 2011 AAOS 'Defensive Medicine' Survey," Columbia University Mailman School of Public Health Clinical Professor Fred Hyde, M.D., 2011.

In a widely-reported recent "survey" of 56[129] or 72[130] Pennsylvania orthopedic surgeons, respondents claim that 19.7 percent of the imaging tests they ordered were for defensive purposes – *i.e.* to avoid being sued. This supposedly amounts to 34.8 percent of total imaging costs because "the most common test was an MRI, an imaging test which costs more than a regular X-ray."[131] Professor Hyde reviewed this study for CJ&D and found:

- "In searching for the actual paper containing these findings, it turns out that there is no paper, much less one peer reviewed prior to publication. Instead, this was a podium presentation by a medical student, accompanied by a faculty supervisor."[132]

- "The methodology, according to news and public relations reports, was this: to ask the ordering doctor whether or not he or she was ordering a test for reasons having to do with 'defensive medicine.'"[133]

- "However, the issues are not straightforward. For example, a moderator of the presentation suggested other possible explanations for the MRI exams. He noted that MRIs and other imaging studies are frequently ordered 'unnecessarily' for reasons *other than malpractice avoidance*.

    - "The moderator noted that many MRIs are required by insurers before those insurers will authorize an arthroscopy (a minimally invasive surgical procedure in which an examination and treatment of damage of the interior of a joint is performed using an arthroscope, an endoscope inserted into the joint through a small incision).

- "The insurers require the imaging study in an attempt to protect against fraud. Orthopedic surgeons believe the MRI study prior to arthroscopy to be unnecessary; this was affirmed by a show of hands in the audience for the San Diego presentation."[134]

- "No mention was made of the potential for fraudulent billing if the MRI studies ordered were not for the benefit of the patient. If the box checked 'defensive' were accompanied by a box that indicated 'no bill to be rendered' or 'bill referring physician' this would undoubtedly have been included in the report. It would be a reasonable assumption that, to the contrary, a bill was rendered to the patient or to the insurance company for the MRIs as ordered. Were the physicians really uninterested in the results of the MRI tests, and willing to risk sanction? Or did they 'check the box' to 'show support' without realizing that it might indicate a potentially fraudulent act?"[135]

- "Appearing in Pennsylvania especially, this study should be regarded primarily as an advocacy position. This advocacy presentation has received disproportionate attention due to its timing in the context of current proposals before the Congress, not because of the credibility of the survey. The difficulty facing physicians especially in Pennsylvania concerning the cost and availability of malpractice insurance are well known, but are due to insurance issues, and not to causes directly related to tort law."[136]

❖ DEFENSIVE MEDICINE AND MEDICARE FRAUD.

A doctor who bills Medicare or Medicaid for tests and procedures done for a personal purpose – *e.g.*, possible lawsuit protection – as opposed to what is medically necessary for a patient, is committing fraud under federal and state Medicare/Medicaid programs.

- The Medicare law states: "It shall be the obligation of any health care practitioner and any other person…who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act…will be provided economically and only when, and to the extent, medically necessary."[137] "[N]o payment may be made under part A or part B for any expenses incurred for items or services…which…are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."[138]

- Providers cannot be paid and/or participate in the Medicare program unless they comply with these provisions, and they impliedly certify compliance with these provisions when they file claims. Thus, if they are not in compliance, the certifications and the claims are false. Providers who do not comply and/or file false claims can be excluded from the Medicare program.[139]

- Perhaps more importantly, the Medicare claim form (Form 1500) requires providers to expressly certify that "the services shown on the form were medically indicated and necessary for the health of the patient."[140] If the services are, to the doctor's knowledge, not medically necessary, the claim is false.

❖ THE REAL REASON DOCTORS ORDER TOO MANY TESTS: PROFIT.

"Hospital Chain Inquiry Cited Unnecessary Cardiac Work," *New York Times*, August 7, 2012.

- "[U]nnecessary – even dangerous – procedures were taking place at some HCA hospitals, driving up costs and increasing profits."

- "HCA, the largest for-profit hospital chain in the United States with 163 facilities, had uncovered evidence as far back as 2002 and as recently as late 2010 showing that some cardiologists at several of its hospitals in Florida were unable to justify many of the procedures they were performing. … In some cases, the doctors made misleading statements in medical records that made it appear the procedures were necessary, according to internal reports."

- "[T]he documents suggest that the problems at HCA went beyond a rogue doctor or two.…"

- "Cardiology is a lucrative business for HCA, and the profits from testing and performing heart surgeries played a critical role in the company's bottom line in recent years."[141]

"The Cost Conundrum: What a Texas town can teach us about health care," *New Yorker*, 2009.

The following exchange took place with a group of doctors and author, Dr. Atul Gawande:[142]

> "It's malpractice," a family physician who had practiced here for thirty-three years said.
>
> "McAllen is legal hell," the cardiologist agreed. Doctors order unnecessary tests just to protect themselves, he said. Everyone thought the lawyers here were worse than elsewhere.
>
> That explanation puzzled me. Several years ago, Texas passed a tough malpractice law that capped pain-and-suffering awards at two hundred and fifty thousand dollars. Didn't lawsuits go down?
>
> "Practically to zero," the cardiologist admitted.
>
> "Come on," the general surgeon finally said. "We all know these arguments are bullshit. There is overutilization here, pure and simple." Doctors, he said, were racking up charges with extra tests, services, and procedures.

"Doctors Reap Benefits By Doing Own Tests," *Washington Post*, 2009.

The paper obtained Wellmark Blue Cross and Blue Shield documents, which showed that in 2005, doctors at a medical clinic on the Iowa-Illinois border were ordering eight or nine CT scans a month in August and September of 2005. But after those doctors bought their own CT scanner, within seven months, those numbers ballooned by 700 percent. The *Post* did a similar analysis of the Wellmark data for doctors in the region and found that after CT scanners were purchased, the number of scans they ordered was triple that of other area doctors who hadn't purchased such equipment. The paper also cited consistent data from the GAO and MedPac. Jean M. Mitchell, a professor for public policy and a health economist at Georgetown University, suggested that getting rid of profit-driven medicine like this "could reduce the nation's health care bill by as much as a quarter."[143]

"For-profit hospitals performing more C-sections," *California Watch*, 2010.

An investigative team recently looked at C-Section rates in California, which has had a $250,000 cap on damages since 1975. It found that from 2005-2007:[144]

- "[W]omen are at least 17 percent more likely to have a cesarean section at a for-profit hospital than at one that operates as a non-profit. A surgical birth can bring in twice the revenue of a vaginal delivery."

- "[S]ome hospitals appear to be performing more C-sections for non-medical reasons – including an individual doctor's level of patience and the staffing schedules in maternity wards, according to interviews with health professionals."

- "In California, hospitals can increase their revenues by 82 percent on average by performing a C-section instead of a vaginal birth…."[145]

"The Empirical Effects of Tort Reform," Cornell University Law School Professor Theodore Eisenberg, 2012.

"On balance, the available evidence does not support a consistent association between liability pressure and increased cesarean rates. Increased cesarean rates can be attributable to factors other than liability pressure and studies with reasonable control groups of physicians without liability pressure tend not to find an association."[146]

"The Cost of Dying: End-of-Life Care," *60 Minutes*, 2010.

- "Last year, Medicare paid $55 billion just for doctor and hospital bills during the last two months of patients' lives. That's more than the budget for the Department of Homeland Security, or the Department of Education. And it has been estimated that 20 to 30 percent of these medical expenses may have had no meaningful impact."

- "[T]here are other incentives that affect the cost and the care patients receive. Among them: the fact that most doctors get paid based on the number of patients that they see, and most hospitals get paid for the patients they admit.…'So, the more M.R.I. machines you have, the more people are gonna get M.R.I. tests?' [Steve] Kroft asked. 'Absolutely,' [Dr. Elliott Fisher, a researcher at the Dartmouth Institute for Health Policy] said."[147]

PART 3: PHYSICIAN SUPPLY AND ACCESS TO HEALTH CARE

❖ "TORT REFORM" IN TEXAS HAS HAD NO EFFECT ON PHYSICIAN SUPPLY.

"Does Tort Reform Affect Physician Supply? Evidence from Texas," University of Illinois Professor of Law and Medicine David A. Hyman et al., 2012.

The methodology of this study, which controls for every conceivable factor, is so accurate that a national "tort reform" proponent admitted changing his mind about the issue after examining this work.[148]

- A "core argument" behind the "tort reform" campaign was that "Texas was hemorrhaging physicians and limiting lawsuits would stop the bleeding. Consistent with this theme, the core pro-tort-reform lobbying organization was named 'Texas Association for Patient Access' ('TAPA')."[149]

- "[T]he assertion by tort reform proponents that Texas experienced an 'amazing turnaround' after suffering an 'exodus of doctors from 2001 through 2003' is doubly false. There was neither an exodus before reform nor a dramatic increase after reform."[150]

- "Texas was not hemorrhaging physicians before tort reform was enacted in 2003."[151] In fact, "The number of [direct patient care] DPC physicians steadily increased,"[152] even while insurance rates were increasing during the nation's last "hard" insurance market. Moreover, "the number of DPC physicians per capita rose steadily from 1993-2003."[153]

- [T]he rate of increase in Texas DPC physicians per capita was lower after reform."[154]

- "[T]ort reform did not solve Texas' physician supply issues."[155]

- **Specialists.** Two specialties (ob-gyn and orthopedic surgery) grew more quickly before tort reform than after. Only a third specialty (neurosurgery) grew more quickly after caps passed, keeping up with population. In other words, "claims of dramatic post-reform inflows of ob-gyns, orthopedic surgeons, or neurosurgeons are unfounded."[156]

- **Primary care physicians**. "The absolute number of DPC physicians grew at roughly the same rate during the pre- and post-reform periods. If anything, the increase was slower, on average, during the eight post-reform years (2004-2011) than in the preceding eight years (1996-2003)."[157]

- **Rural areas.** "[T]here is no evidence that tort reform materially affected the supply of DPC physicians, specialists, or physicians practicing in rural areas. These findings should not be surprising – they are generally consistent with prior multi-state studies of the relationship between tort reform and physician supply."[158]

Data Cited By The Texas Medical Board Are Misleading And Wrong.

The Texas Medical Board (TMB) often cites statistics showing a post-2003 increase in "the number of applications to practice medicine it receives, the number of licenses it issues, and the number of doctors practicing in identified specialties by county."[159] These data are extremely problematic.

- "[S]imply adding up post-reform licenses"[160] means little because of others factors influencing physician licenses in Texas during this time.
    - The authors note, "In a 2010 report, the Texas Department of State Health Services suggested that an increase in 'direct patient care' physicians in 2005 was 'partially due to Hurricane Katrina.'"[161]
- TMB "data on applications and new licenses (which is what tort reform proponents have focused on) is flawed because it does not reflect physicians leaving Texas or retiring. Without knowing both how many new doctors arrived and how many old doctors departed, one cannot tell whether the number of doctors in Texas rose, fell, or was unchanged."[162]
- TMB "licensing data do not indicate how many physicians are engaged in patient care. Many licensed physicians are researchers, administrators, or otherwise occupied with non-clinical tasks,"[163] *i.e.*, doctors who do not treat patients.
    - The appropriate statistics are those used by the Texas Department of State Health Services, which are publicly available, reflecting active DPC physicians. It is these data on which the authors' of this study base their findings.[164]

What Determines Physician Supply in Texas and Elsewhere.

- "Physician supply appears to be primarily driven by factors other than liability risk, including population trends, location of the physician's residency, job opportunities within the physician's specialty, lifestyle choices, and demand for medical services, including the extent to which the population is insured."[165]

Texas's Data Collection Laws, Which Most States Do Not Have, Are Critical For This Kind Of Analysis.

- The authors write, "We close by emphasizing the importance of publicly available reliable longitudinal data, collected on a time-consistent basis. It would not have been possible to perform this study (or the other studies we have done using Texas' closed

claims data) without this data. Texas should be commended for creating a closed claims database in 1988, and maintaining it over the intervening decades. Other states should emulate Texas."[166]

❖ MANY STUDIES CONFIRM THAT "TORT REFORM" HAS HAD NO EFFECT ON PHYSICIAN SUPPLY NATIONALLY.

"The Empirical Effects of Tort Reform," Cornell University Law School Professor Theodore Eisenberg, 2012.

> "If increasing premiums drive exit decisions, then programs alleviating premiums should have effects. But Smits et al. (2009) surveyed all obstetrical care providers in Oregon in 2002 and 2006. Cost of malpractice premiums was the most frequently cited reason for stopping maternity care. An Oregon subsidy program for rural physicians pays 80 percent of the professional liability premium for an ob/gyn and 60 percent of the premium for a family or general practitioner. Receiving a malpractice subsidy was not associated with continuing maternity services by rural physicians. Subsidized physicians were as likely as nonsubsidized physicians to report plans to stop providing maternity care services. And physician concerns in Oregon should be interpreted in light of the NCSC finding, described above, that this was a period of substantial decline of Oregon medical malpractice lawsuit filings."[167]

"Changes In Physician Supply And Scope Of Practice During A Malpractice Crisis: Evidence From Pennsylvania," Harvard School of Public Health Professor Michelle Mello et al., 2007.

> In April 2007, Mello and her colleagues published a study of physician supply in Pennsylvania in the peer-reviewed journal, *Health Affairs.* The authors "looked at the behavior of physicians in 'high-risk' specialties – practice areas such as obstetrics/gynecology and cardiology for which malpractice premiums tend to be relatively high – over the years from 1993 through 2002. They found that contrary to predictions based on the findings of earlier physician surveys, only a small percentage of these high-risk specialists reduced their scope of practice (for example, by eliminating high-risk procedures) in the crisis period, 1999-2002, when malpractice insurance premiums rose sharply."[168]
>
> "What's more, the proportion of high-risk specialists who restricted their practices during the crisis period was not statistically different from the proportion who did so during 1993-1998, before premiums spiked. 'It doesn't appear that the restrictions we did observe after 1999 were a reaction to the change in the malpractice environment,' said Mello, the C. Boyden Gray Professor of Health Policy and Law at the Harvard School of Public Health."[169]

Dartmouth Medical School Professor of Pediatrics and Health Policy David Goodman, M.D., M.S., 2009.

Goodman is co-investigator of the highly respected Dartmouth Atlas, which analyzes and ranks health care spending and has been the basis of a lot of discussion about why certain areas of the country are so costly. In an email to the Center for Justice & Democracy, he said: "We haven't explicitly analyzed this, but I agree with the impression that physician supply in general bears no relationship to state tort reform, or lack thereof."[170]

"The Effect of Malpractice Liability on the Delivery of Health Care," National Bureau of Economic Research, 2004.

In August 2004, National Bureau of Economic Research researchers found: "The fact that we see very little evidence of widespread physician exodus or dramatic increases in the use of defensive medicine in response to increases in state malpractice premiums places the more dire predictions of malpractice alarmists in doubt. The arguments that state tort reforms will avert local physician shortages or lead to greater efficiencies in care are not supported by our findings."[171]

"Region Gains Doctors Despite Malpractice Bills," *Cincinnati Enquirer,* 2004.

The paper reviewed public records in Ohio in the midst of that state's medical malpractice insurance crisis. The investigation found "more doctors in the state today than there were three years ago … '[T]he data just doesn't translate into doctors leaving the state,' says Larry Savage, president and chief executive of Humana Health Plan of Ohio."[172]

Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care, U.S. General Accounting Office, 2003.

On August 29, 2003, the U.S. General Accounting Office (GAO) released a study[173] ostensibly to find support for American Medical Association (AMA) assertions that a widespread health care access "crisis" existed in this country caused by doctors' medical malpractice insurance problems. The GAO found that the AMA and doctors groups had based their claims on information GAO determined to be "inaccurate"[174] and "not substantiated,"[175] and that to the extent there are a few access problems, many other explanations can be established "unrelated to malpractice,"[176] that problems "did not widely affect access to health care,"[177] and/or "involved relatively few physicians."[178] The health care access problems that GAO could confirm were isolated and the result of numerous factors having nothing at all to do with the legal system. Specifically, GAO found that these pockets of problems "were limited to scattered, often rural, locations and in most cases providers identified long-standing factors in addition to malpractice pressures that affected the availability of services."[179]

Earlier Studies.

Past studies have also shown no correlation between where physicians decide to practice and state liability laws. One study found that, "despite anecdotal reports that favorable state tort environments with strict … tort and insurance reforms attract and retain physicians, no evidence suggests that states with strong … reforms have done so."[180] A 1995 study of the impact of Indiana's medical malpractice "tort reforms," which were enacted with the promise that the number of physicians would increase, found that "data indicate that Indiana's population continues to have considerably lower per capita access to physicians than the national average."[181]

❖ LIFESTYLE AND AGE CONSIDERATIONS ARE THE MOST IMPORTANT FACTOR FOR DETERMINING NOT ONLY A DOCTOR'S CHOICE OF LOCATION, BUT ALSO HIS OR HER CHOICE OF SPECIALTY.

"Young Doctors and Wish Lists: No Weekend Calls, No Beepers," *New York Times,* 2004.

> "Today's medical residents, half of them women, are choosing specialties with what experts call a 'controllable lifestyle.'…What young doctors say they want is that 'when they finish their shift, they don't carry a beeper; they're done,' said Dr. Gregory W. Rutecki, chairman of medical education at Evanston Northwestern Healthcare, a community hospital affiliated with the Feinberg School of Medicine at Northwestern University…
>
> "Lifestyle considerations accounted for 55 percent of a doctor's choice of specialty in 2002, according to a paper in the Journal of the American Medical Association in September by Dr. [Gregory W.] Rutecki and two co-authors. That factor far outweighs income, which accounted for only 9 percent of the weight prospective residents gave in selecting a specialty."[182] For example, compared to dermatology, which is becoming a more competitive specialty, "'The surgery lifestyle is so much worse,' said Dr. [Jennifer C.] Boldrick, who rejected a career in plastic surgery. 'I want to have a family. And when you work 80 or 90 hours a week, you can't even take care of yourself.'"[183]

NYPIRG et al., *The Doctor* Is *In: New York's Increasing Number of Doctors*, 2004.

> A University of California-San Francisco study of New York doctors found that the main reason doctors cease providing obstetrics care is advancing age. The UCSF study, of New York State physicians during the mid-1980s insurance crisis, found no association between malpractice premiums and doctors' decisions to quit. The report did find that the decrease in doctors practicing obstetrics was associated with the *length of time* since receiving a medical license in New York. This relationship "very likely represents the phenomenon of physician retiring from practice or curtailing obstetrics as they age."[184]

PART 4: MEDICAL MALPRACTICE INSURANCE

❖ MEDICAL MALPRACTICE INSURERS HAVE BEEN INCREDIBLY PROFITABLE IN RECENT YEARS.

True Risk: Medical Liability, Malpractice Insurance And Health Care, Americans for Insurance Reform, 2009.

- In the report *True Risk*, Americans for Insurance Reform (AIR) found that no matter how profits were measured, medical malpractice insurers were doing incredibly well, especially when compared to every other sector in the economy.[185] Medical malpractice insurers admitted that they had "a very good" 2008.[186] This came "after posting record profits in 2007."[187] A.M. Best predicted that their "operating profits will continue through 2009."[188] And a quick look at the most recent data shows this to be true.

- The medical malpractice insurance industry had an overall return on net worth of 15.6%, *well over* the 12.5% overall profit for the entire property/casualty industry.[189] According to the National Association of Insurance Commissioners most recent data, overall return on net worth for the medical malpractice insurers for 2009 remains high at 15.3%.

- "Profitability can also be measured by the loss ratio, which compares the premiums that insurers take in and the money expected to be paid in claims. The lower the loss ratio, the less the insurer expects to pay for claims and the more profitable the insurer likely is (assuming all other things are equal.)"[190] According to A.M. Best, "the loss ratio for medical malpractice insurers has been declining for at least five years.[191] In 2008, it was remarkably low, at 61.1%. Put another way, medical malpractice insurers believe they will pay out in claims only 61.1 cents for each premium dollar they take in. The rest goes towards overhead and profit."[192] This profit is in addition to the profit the insurer makes by investing premiums.

- "Another way to illustrate how well insurers have been doing in recent years is by examining "reserves" – the money set aside for future claims. Reserves are often manipulated by insurers for reasons having little to do with actual claims. Indeed, according to A.M. Best, reserves were "redundant" (*i.e.* excessive) during the last hard market – 2002 to 2004.[193] In those years, insurers told lawmakers that they needed dramatically to raise rates for doctors in order to pay future claims. It wasn't true. As reserves went up, so did rates."[194] [195]

- Reserves are now dropping at a substantial rate, with a whopping 13.6% drop in the last two years examined by AIR.[196]

❖ MEDICAL MALPRACTICE PREMIUMS HAVE BEEN DROPPING SINCE 2006; INFLATION-ADJUSTED, THEY ARE NEARLY THE LOWEST THEY HAVE BEEN IN OVER 30 YEARS.

"First Look: 2012 First Quarter Results for Medical Professional Liability Specialty Writers," *Medical Liability Monitor*, July 2012.

> "[P]remiums are still declining" and "insurers continue to benefit from the persistent, favorable reserve releases…first-quarter-2012 direct written premium is down another 0.9 percent compared to the first quarter 2011. … Direct written premium for this composite is down almost 20 percent since its peak in 2006."[197] [Note that "favorable reserve releases" derive from the previous "hard market" when insurers bloated reserves to justify rate hikes.]

True Risk: Medical Liability, Malpractice Insurance And Health Care, Americans for Insurance Reform, 2009.

- "According to A.M. Best, after reaching a high of 14.2% in 2003 during the last hard market, medical malpractice premium growth has been dropping, decreasing by 6.6% nationally in 2007, and an additional 5.3% in 2008."[198]

- "The insurance pure premium[199] or loss costs,[200] is particularly important to examine. This is the one component of an insurance rate that should be affected by verdicts, settlements, payouts or so-called "tort reform." It is the largest part of the premium dollar for most lines of insurance."[201] The Insurance Services Office (ISO)[202] "shows the same cyclical pattern with the biggest increases during the hard market of 2002-2005, and dropping steadily since then with 2008 seeing an astonishing 11% decrease. This confirms that we are experiencing a very soft market."[203] Moreover, "this decrease might have been even greater had 17 states not limited the decrease to 20%, likely because ISO wanted to control this drop. Most likely, this result was due to the recognition that, with profits as high as they were, medical malpractice insurance for doctors was greatly overpriced in prior years."[204]

❖ PREMIUMS HAVE DROPPED IRRESPECTIVE OF WHETHER "TORT REFORMS" HAVE BEEN ENACTED IN ANY PARTICULAR STATE.

True Risk: Medical Liability, Malpractice Insurance And Health Care, Americans for Insurance Reform, 2009.

- "States with little or no restrictions on patients' legal rights have experienced the same level of liability insurance rate changes as those states that enacted severe restrictions on patients' rights."[205]

- "Compare, Missouri and Iowa, two neighboring Midwest states. Missouri had a cap since the mid-1980s, as well as other 'tort reform' in medical malpractice cases. (This cap was struck down as unconstitutional in July 2012 - 26 years after its enactment.[206]) Iowa never had a cap. In the last five years examined, Missouri's pure premium increased 1%. Iowa's dropped 6%. Among states that had pure premium increases of more than 5% in the last five years were states with significant medical malpractice limits like FL, NV, and UT, and states with fewer restrictions like NH, VT and WY."[207]

❖ "CAPS" DO *NOT* LOWER INSURANCE PREMIUMS FOR DOCTORS.

Comparing Maryland and Missouri: Two states that enacted severe caps on damages in the mid-1980s, only to be hit with huge rate hikes during the last hard market.

- **Maryland.** In the mid-2000s, Maryland was called an American Medical Association (AMA) "problem state"[208] and a "crisis state" according to the American College of Obstetricians and Gynecologists because insurance rates had suddenly jumped.[209] Yet Maryland had had a cap on non-economic damages since 1986, originally $350,000 but later increased somewhat.[210] Despite the cap, the state experienced premiums that "rose by more than 70 percent in the last two years."[211] This caused lawmakers to push for, once again, even more restrictions on patients' rights in a special session called by the Governor in 2004 ostensibly "to combat the high cost of malpractice insurance."[212]

- **Missouri.** It was also identified by the AMA as a so-called "crisis state,"[213] yet had had a cap on non-economic damages since 1986. (This cap was struck down as unconstitutional in July 2012 – 26 years after its enactment.[214]) The cap started at $350,000 and was adjusted annually for inflation, reaching $557,000 in 2003.[215] "New medical malpractice claims dropped 14 percent in 2003 to what the [Missouri Department of Insurance] said was a record low, and total payouts to medical malpractice plaintiffs fell to $93.5 million in 2003, a drop of about 21 percent from the previous year."[216] And "[t]he National Practitioner Data Bank, a federally mandated database of malpractice claims against physicians, found that the number of paid claims in Missouri fell by about 30 percent since 1991. The insurance department's database found that paid claims against physicians fell 42.3 percent during the same time period."[217] *Yet doctors' malpractice insurance premiums rose by 121 percent between 2000 and 2003.*[218]

Other States.

- **Florida.** "When Gov. Jeb Bush and House Speaker Johnnie Byrd pushed through a sweeping medical malpractice overhaul bill … the two Republican leaders vowed in a joint statement that the bill would 'reduce ever-increasing insurance premiums for Florida's physicians . . . and increase physicians' access to affordable insurance coverage.'"[219] But, insurers soon followed up with requests to increase premiums by as much as 45 percent.

- **Mississippi.** Four months after "caps" passed, investigative news articles reported that surgeons still could not find affordable insurance and that many Mississippi doctors were still limiting their practice or walking off the job in protest.[220]

- **Nevada.** Within weeks of enactment of "caps" in the summer of 2002, two major insurance companies proclaimed that they would not reduce insurance rates for at least another year to two, if ever. The Doctors Company, a nationwide medical malpractice insurer, then filed for a 16.9 percent rate increase. Two other companies filed for 25 percent and 93 percent rate increases.[221]

- **Ohio.** Almost immediately after "tort reform" passed, all five major medical malpractice insurance companies in Ohio announced they would not reduce their rates. One insurance executive predicted his company would seek a 20 percent rate increase.[222]

- **Oklahoma.** After "caps" passed in 2003, the third-largest medical malpractice insurer in the state raised its premiums 20 percent, followed by an outrageous 105 percent rate hike in 2004.[223] The largest insurance company, which is owned by the state medical association, requested an astounding 83 percent rate hike just after "tort reform" passed (which was approved on the condition it be phased in over three years).[224]

- **Texas.** During the 2003 campaign for Prop. 12 – the "tort reform" referendum that passed – ads promised rate cuts if caps were passed. Right after the referendum passed, major insurers requested rate hikes as high as 35 percent for doctors and 65 percent for hospitals.[225] In April 2004, after one insurer's rate hike request was denied, it announced it was using a legal loophole to avoid state regulation and increase premiums 10 percent without approval.[226] In a 2004 filing to the Texas Department of Insurance, GE Medical Protective revealed that the state's non-economic damage cap would be responsible for no more than a 1 percent drop in losses.[227]

❖ INDUSTRY INSIDERS HAVE REPEATEDLY SAID THAT CAPPING DAMAGES WILL NOT LOWER INSURANCE RATES.

- **American Insurance Association:** "[T]he insurance industry never promised that tort reform would achieve specific premium savings."[228]

- **Sherman Joyce, President, American Tort Reform Association:** "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates."[229]

- **Victor Schwartz, General Counsel, American Tort Reform Association:** "[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years.'"[230]

- **State Farm Insurance Company (Kansas):** "[W]e believe the effect of tort reform on our book of business would be small. … [T]he loss savings resulting from the non-economic cap will not exceed 1% of our total indemnity losses….."[231]

- **Aetna Casualty and Surety Co. (Florida):** After Florida enacted what Aetna Casualty and Surety Co. characterized as "full-fledged tort reform," including a $450,000 cap on non-economic damages, Aetna did a study of cases it had recently closed and concluded that Florida's tort reforms would not effect Aetna's rates. Aetna explained that "the review of the actual data submitted on these cases indicated no reduction of cost."[232]

- **Allstate Insurance Company (Washington State):** In asking for a 22% rate increase following passage of tort reform in Washington State, including a cap on all damage awards, the company said, "[O]ur proposed rate would not be measurably affected by the tort reform legislation."[233]

- **Great American West Insurance Company (Washington State):** After the 1986 Washington tort reforms, the Great American West Insurance Company said that on the basis of its own study, "it does not appear that the 'tort reform' law will serve to decrease our losses, but instead it potentially could increase our liability. We elect at this point, however, not to make an upward adjustment in the indications to reflect the impact of the 'tort reform' law."[234]

- **Vanderbilt University:** A regression analysis conducted by Vanderbilt University Economics Professor Frank Sloan found that caps on economic damages enacted after the mid 1970's insurance crisis had no effect on insurance premiums.[235]

❖ STRONG INSURANCE REGULATORY LAWS ARE THE ONLY WAY TO CONTROL INSURANCE RATES FOR DOCTORS AND HOSPITALS.

Comparing California and Illinois: Two states that enacted both severe caps on damages and strong insurance regulation.

CALIFORNIA

Cap. In 1975, California enacted a severe $250,000 cap on non-economic damages, the first in the nation. This cap has greatly reduced the number of genuine malpractice cases brought in California.

- Despite the reduction of legitimate cases, between 1975 and 1988, doctors' premiums in California increased by 450 percent, rising faster than the national average.[236]

- As a result of the cap, California's medical malpractice insurance industry became so bloated that "as little as 2 or 3 percent of premiums are used to pay claims" and "the state's biggest medical malpractice insurer, Napa-based The Doctors Company, spent only 10 percent of the $179 million collected in premiums on claims in 2009." Insurance Commissioner Dave Jones said that "insurers should reduce rates paid by doctors, surgeons, clinics and health providers while his staff scrutinizes the numbers."[237]

Insurance regulation: In 1988, California voters passed a stringent insurance regulatory law, Proposition 103 (Prop. 103), which ordered a 20% rate rollback, forced companies to open their books and get approval for any rate change before it takes effect, and allowed the public to intervene and challenge excessive rate increases.

- In the twelve years after Prop. 103 (1988-2000), malpractice premiums dropped 8 percent in California, while nationally they were up 25 percent.[238]

- During the period when every other state was experiencing skyrocketing medical malpractice rate hikes in the mid-2000s, California's regulatory law led to public hearings on rate requests by medical malpractice insurers in California, which resulted in rate hikes being lowered three times in two years,[239] saving doctors $66 million.

- Prop. 103 has allowed the state Insurance Commissioner to take action and lower excessive insurance rates for doctors. According to an October 2012 news release issued by the California Department of Insurance,[240]

    - "Insurance Commissioner Dave Jones today announced the second medical malpractice rate reduction this year for NORCAL Mutual Insurance Company's physician and surgeon program. The company's 6.9 percent reduction saves

primarily Southern California doctors approximately $8.5 million annually. This company initiated rate reduction follows a Department ordered 7.1 percent decrease in March for an overall savings of $18 million this year alone for physicians and surgeons insured by NORCAL Mutual."

- "Last year Commissioner Jones ordered the top six medical malpractice insurance companies in California to submit rate filings to the Department of Insurance to justify their current rates. After a thorough review of those filings, Commissioner Jones called for rate reductions. As a result of the Commissioner's rejection of excessive rates, all six companies lowered their medical malpractice rates," amounting to "a total savings to medical providers of $52 million…."

- "'I'm pleased the medical malpractice rates are continuing to be decreased under the Department's rate review process and authority,' said Commissioner Jones. 'These medical malpractice rate reductions show the important role that Proposition 103, which authorizes the insurance Commissioner to reject excessive rate hikes for property and casualty insurance, including medical malpractice insurance, has played in curbing medical malpractice rates since it was passed in 1988.'"

ILLINOIS

In 2005, Illinois enacted a non-economic damages cap on compensation for injured patients ($500,000 for doctors and $1,000,000 for hospitals) and a very strong insurance regulatory law. In February 2010, the Illinois Supreme Court struck down this cap as unconstitutional.[241] Because of a non-severability clause, the insurance regulatory law was struck down, as well. In the five years these laws were in place, the following occurred:

Cap: The cap never really affected settlements or insurance rates in Illinois during the five years it existed. This was acknowledged in a May 2010 webinar sponsored by A.M. Best, where a Chicago-based insurance attorney said:

> "It may be headlines in other places but here in Cook County [Illinois] I think that the Supreme Court's decision in *Lebron* was fully anticipated and discounted. None of the settlements that I've been involved in for the last couple of years paid the slightest attention to the caps anymore. There was almost a universal acceptance that it would be overturned by the Supreme Court. In fact it was overturned in Cook County two years ago. Lebron was a Cook County case going up, so the caps haven't been law here for quite some time."[242]

Insurance Regulation: The strong insurance regulatory reforms *did* take effect and had an impact.

In October 2006, the Illinois Division of Insurance announced that an Illinois malpractice insurer, Berkshire Hathaway's MedPro, would be expanding its coverage and cutting

premiums for doctors by more than 30 percent. According to state officials and the company itself, this was made possible because of new insurance regulatory law enacted by Illinois lawmakers in 2005, and expressly not the cap on compensation for patients.[243] The new law required malpractice insurers to disclose data on how to set their rates. This, according to Michael McRaith, director of the state's Division of Insurance, allowed MedPro to "set rates that are more competitive than they could have set before."[244]

In February 2010, the Illinois Division of Insurance released data showing that insurance regulation had greatly improved the medical malpractice insurance environment with expanded coverage and lower premiums for doctors.[245] Specifically, the insurance division said:

> "The 2005 Reform Laws imposed changes to the Illinois Insurance Code that improved insurer reporting and transparency requirements and enhanced the Department's rate oversight authority. Since 2005, the Department has observed improvements in the medical malpractice insurance market. In particular, the Department observed:
>
> - **A decrease in medical malpractice premiums.** Gross premium paid to medical malpractice insurers has declined from $606,355,892 in 2005 to $541,278,548 in 2008;
>
> - **An increase in competition among companies offering medical malpractice insurance.** In 2008, 19 companies offering coverage to physicians/surgeons each collected more than $500,000 in premiums, an increase from 14 such companies in 2005; and
>
> - **The entry into Illinois of new companies offering medical malpractice insurance.** In 2008, five companies collected more than $22,000,000 in combined physicians/surgeons premiums – and at least $1,000,000 each in premiums – that did not offer medical malpractice insurance in 2005."[246]

PART 5: PATIENT SAFETY

❖ MEDICAL ERRORS OCCUR IN ALARMING NUMBERS AND ARE EXTREMELY COSTLY.

It has been over a decade since the Institute of Medicine's (IOM) seminal study "To Err is Human"[247] was published, which found that between 44,000 and 98,000 patients are killed (and many more injured) in hospitals each year due to medical errors, costing the nation between $17 billion and $29 billion each year. Recent studies confirm that patient safety has not improved and has gotten worse.

Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, Institute of Medicine, 2012

- "More than a decade since the Institute of Medicine's (IOM) *To Err Is Human: Building a Safer Health System* was published, the U.S. health care system continues to fall far short of its potential. While *To Err Is Human* and other IOM reports, including the *Crossing the Quality Chasm* series, have helped spark numerous efforts to improve practices, persistent health care underperformance and high costs highlight the considerable challenge of bringing isolated successes to scale. The nation has yet to see the broad improvements in safety, accessibility, quality, or efficiency that the American people need and deserve."[248]

- "As with many other aspects of the health care enterprise, a variety of financial incentives and payment models are currently in use. Some are modeled on a fee-for-service structure and some on a capitated or global payment system; other models exist as well. The most common models for both public and private plans tend to pay clinicians based on the volume of individual procedures and tests. Higher-quality care rarely is rewarded by payment and contracting policies, so that there is little relationship between the cost or price of care and the quality and outcomes of the care provided (Fisher et al., 2003; Office of Attorney General of Massachusetts, 2011; Yasaitis et al., 2009). One study found, on average, only a 4.3 percent correlation (as measured by a coefficient of determination) between the quality of care delivered and the price of the medical service; indeed, higher prices often were associated with lower quality (Office of Attorney General of Massachusetts, 2011)."[249]

- "As the IOM committee reports, every missed opportunity for improving health care results in unnecessary suffering. By one estimate, almost 75,000 needless deaths could have been averted in 2005 if every state had delivered care on par with the best performing state. Current waste diverts resources; the committee estimates $750 billion in unnecessary health spending in 2009 alone."[250] As the *New York Times* explains, "The institute's analysis of 2009 data shows $210 billion spent on unnecessary services, like repeated tests, and $130 billion spent on inefficiently delivered services, like a scan

performed in a hospital rather than an outpatient center."[251] Moreover, "It also shows the health care system wasting $75 billion a year on fraud, $55 billion on missed prevention opportunities and a whopping $190 billion on paperwork and unnecessary administrative costs."[252]

"Transformation of Health System Needed to Improve Care and Reduce Costs," National Academies, 2012.

- "'The threats to Americans' health and economic security are clear and compelling, and it's time to get all hands on deck,' said committee chair Mark D. Smith, president and CEO, California HealthCare Foundation, Oakland. 'Our health care system lags in its ability to adapt, affordably meet patients' needs, and consistently achieve better outcomes.'"[253]

- "Health care costs have increased at a greater rate than the economy as a whole for 31 of the past 40 years. Most payment systems emphasize volume over quality and value by reimbursing providers for individual procedures and tests rather than paying a flat rate or reimbursing based on patients' outcomes, the report notes. It calls on health economists, researchers, professional societies, and insurance providers to work together on ways to measure quality performance and design new payment models and incentives that reward high-value care."[254]

"What's Possible for Health Care?" Institute of Medicine, 2012.

"1/3 of hospitalized patients are harmed during their stay."[255]

Health Affairs, 2011.

The April 2011 edition of *Health Affairs* contained three important articles about medical errors and their costs:

"Global Trigger Tool' Shows That Adverse Events In Hospitals May Be Ten Times Greater Than Previously Measured," University of Utah Associate Professor of Medicine David Classen et al.

This study found that medical errors occur in one-third of hospital admissions, as much as ten times more frequently than previously estimated.[256] This is because adverse event detection methods commonly used to track patient safety in the United States today — voluntary reporting and the Agency for Healthcare Research and Quality's Patient Safety Indicators — are woefully inadequate, missing as many as 90 percent of hospital errors.[257] "Hospitals that use such methods alone to measure their overall performance on patient safety may be seriously misjudging actual performance," the researchers wrote. "Reliance on such methods could produce misleading conclusions about safety in the U.S. health-care system and could misdirect patient-safety improvement efforts."

Chief medical mistakes uncovered in the report: "medication errors, including getting the wrong drug or being given the wrong dose of the right drug; surgical errors, such as having an operation done on the wrong site or surgical gaffes that result in bleeding or infection; and hospital-acquired infections, which often result from poor sanitation."[258] As lead researcher Dr. David C. Classen, an associate professor of medicine at the University of Utah, put it, "The more you look for errors, the more you find."[259]

"The Social Cost Of Adverse Medical Events, And What We Can Do About It," National Center for Policy Analysis.

In 2006, medical mistakes contributed to up to 6.1 million injuries and 187,135 deaths in the United States.[260] Lost lives and disabilities caused by medical error cost between $393 billion and $958 billion in 2006, equivalent to 18-45% of total US health-care spending in that year.[261] "For every dollar that was spent in the health care system, about 18 to 45 cents of that dollar went to hurting someone," explained co-author Pamela Villarreal in an April 7th briefing.[262]

"The $17.1 Billion Problem: The Annual Cost Of Measurable Medical Errors," Milliman Inc.

An analysis of insurance claims from 2001 through 2008 found approximately 564,000 injuries to patients admitted to U.S. hospitals and 1.8 million injuries to people using outpatient services.[263] Preventable medical mistakes that harmed patients cost the United States $17.1 billion in 2008.[264] According to the researchers, "ten types of error account for more than two-thirds of the total cost of errors," with the most common ones being pressure ulcers, postoperative infections and persistent back pain following back surgery.[265] The single most expensive cause of harm – infection after surgery, with more than 252,000 infections costing $3.36 billion. The most common preventable event – pressure ulcers, with nearly 375,000 cases costing $3.27 billion.[266]

"Hospital Acquired Condition Rates," Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, 2011.

Medicare claims from October 2008 through June 2010 show elderly and disabled patients suffering thousands of serious, preventable injuries in the nation's 4,700 hospitals.[267] Since October 2008, Medicare stopped reimbursing hospitals for such medical errors, known as "never events" because they should never happen.[268] Errors included: 10,564 instances of falls and trauma, 6,868 catheter-associated bloodstream infections, 5,928 catheter-associated urinary tract infections, 2,521 cases of pressure ulcers (bedsores), 944 manifestations of poor glycemic control and 484 instances of foreign objects left behind during surgeries.[269] "By making [hospital acquired conditions or 'HAC'] data transparent, CMS sheds light on those preventable events where patients are harmed while seeking care," the agency said in a press release.[270]

Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, Office of Inspector General, U.S. Department of Health and Human Services, 2010.

- "Of the nearly 1 million Medicare beneficiaries discharged from hospitals in October 2008, about ***1 in 7*** experienced an adverse event that met at least 1 of our criteria (13.5 percent)."[271] "An estimated 1.5 percent of Medicare beneficiaries experienced an event that contributed to their deaths, which projects to 15,000 patients in a single month."[272]

- "Physician reviewers determined that ***44 percent of adverse and temporary harm events were clearly or likely preventable***. … Preventable events were linked most commonly to medical errors, substandard care, and lack of patient monitoring and assessment."[273] "Because many adverse events we identified were preventable, our study confirms the need and opportunity for hospitals to significantly reduce the incidence of events."[274]

- "Hospital care associated with adverse and temporary harm events cost Medicare an estimated $324 million in October 2008. Sixteen percent of sample beneficiaries in the Medicare Inpatient Prospective Payment System who experienced events incurred additional Medicare costs as a result. The added costs equate to an estimated 3.5 percent of Medicare's expenditure for inpatient care during October 2008. To give these figures an annual context, 3.5 percent of the $137 billion Medicare inpatient expenditure for FY 2009 equates to ***$4.4 billion*** spent on care associated with events. Two-thirds of Medicare costs associated with events were the result of entire additional hospital stays necessitated by harm from the events. Additionally, these Medicare cost estimates do not include additional costs required for follow-up care after the sample hospitalizations."[275]

"Temporal Trends in Rates of Patient Harm Resulting from Medical Care," Harvard Medical School Associate Professor of Medicine and Pediatrics Christopher P. Landrigan, M.D., M.P.H. et al., 2010.

- "In a statewide study of 10 North Carolina hospitals, we found that ***harm resulting from medical care was common***, with little evidence that the rate of harm had decreased substantially over a 6-year period ending in December 2007.… Since North Carolina has been a leader in efforts to improve safety, a lack of improvement in this state suggests that further improvement is also needed at the national level. [276]

- "Our findings validate concern raised by patient-safety experts in the United States and Europe that harm resulting from medical care remains very common. Though disappointing, the absence of apparent improvement is not entirely surprising. Despite substantial resource allocation and efforts to draw attention to the patient-safety epidemic on the part of government agencies, health care regulators, and private organizations, the penetration of evidence-based safety practices has been quite modest. For example, only 1.5% of hospitals in the United States have implemented a comprehensive system of electronic medical records, and only 9.1% have even basic electronic record keeping in place; only 17% have computerized provider order entry. Physicians-in-training and nurses alike routinely work hours in excess of those proven to be safe. Compliance with even simple interventions such as hand washing is poor in many centers."[277]

❖ SOME HOSPITAL DEPARTMENTS ARE PARTICULARLY UNSAFE.

Intensive Care Units (ICUs).

- According to a 2012 study from the Johns Hopkins University School of Medicine, "as many as 40,500 critically ill patients in the United States may die annually when clinicians fail to diagnose hidden life-threatening conditions such as heart attack and stroke. The unexpectedly high frequency of deadly misdiagnosis in hospital intensive care units or ICUs was 'surprising and alarming,' said Dr. Bradford Winters, the lead author of the study."[278]

- Specifically, "one in four patients – 28 percent – had a missed diagnosis at the time of their death. In about 8 percent of patients, the misdiagnosis was serious enough to have caused or contributed to the patients' deaths…."[279] These ICU errors are "as much as 50 percent more common than that in general hospital patients."[280]

Emergency Rooms.

The hospital location with the highest proportion of negligent adverse events (52.6 percent) is the emergency department,[281] where people without health insurance often go for primary care.

❖ THE SITUATION IS FAR WORSE BECAUSE MAJOR ERRORS GO UNREPORTED.

Hospital Incident Reporting Systems Do Not Capture Most Patient Harm and *Few Adverse Events in Hospitals Were Reported to State Adverse Event Reporting Systems*, Office of Inspector General, U.S. Department of Health and Human Services, 2012.

- According to a January 2012 study, "Hospital employees recognize and report only one out of seven errors, accidents and other events that harm Medicare patients while they are hospitalized." This massive error "underreporting" problem at hospitals is because hospitals employees do not seem to know what patient harm is and if they do, they think it is someone else's job to report it. Specifically, "[T]he problem is that hospital employees do not recognize 'what constitutes patient harm' or do not realize that particular events harmed patients and should be reported.… In some cases … employees assumed someone else would report the episode, or they thought it was so common that it did not need to be reported, or 'suspected that the events were isolated incidents unlikely to recur.'"[282]

- A July 2012 follow-up study found that "[a]lthough half of States operated adverse event reporting systems in 2008, hospitals reported few events to State systems. For all but one event that was not reported to State systems as required, the hospitals did not identify the events within internal incident reporting systems. This indicates that low reporting to State systems is more likely to result from hospital failure to identify events than from hospitals' neglecting to report known events."[283]

  Moreover, "[m]any of the events not reported to State systems as required involved serious harm to hospitalized Medicare beneficiaries. Six of the thirty-two events contributed to patient death, including cases involving lack of patient monitoring and missed diagnoses….Other unreported events required the use of life-sustaining interventions, indicating that hospital staff were clearly alerted to a problem but still did not report the events."[284]

  "Further, the less serious, temporary harm events that hospitals did not report included many events that can become serious if not ameliorated, such as excessive bleeding and intravenous volume overload. The treatment required to stop the progression of these events also implies that in each case, hospital staff were likely aware of the patient's condition but did not perceive the condition as an event."[285]

"Year after report, patients still face risks," *Albany Times Union*, 2010.

- A September 2010 *Hearst* newspapers investigation revealed that most states fail to report medical errors.[286] According to the study, "Twenty-three states don't have a

medical-error detection program. Even those with mandatory programs miss a majority of the harm."[287]

- "Outside of New York and Pennsylvania, which have robust error reporting systems, a Hearst sampling showed other states with mandatory programs didn't account for between 97 percent and 75 percent of harmful events — based on a conservative definition of harm."[288]

State-specific error reporting problems.

- **California.** "Eighty-seven hospitals – more than 20% of the 418 hospitals covered under a law that took effect in 2007 – have made no reports of medical errors, according to the California Department of Public Health."[289]

- **Nevada.** After examining 425,000 billing records in 2008 and 2009, the *Las Vegas Sun* "identified 3,689 cases of preventable harm that could be categorized as sentinel events, meaning Nevada law requires them to be reported to the state."[290] According to the *Sun*, "During those same two years, all Nevada hospitals reported just 402 sentinel events."[291] "In its investigation, the Sun found that at the 13 acute-care hospitals in the Las Vegas Valley in 2008-09, there were: 710 surgical accidents; 2,010 cases where patients were infected with lethal bacteria; 969 cases of injuries such as bloodstream infections involving central-line catheters, advanced-stage pressure sores and postoperative falls."[292]

- **North Carolina.** "Most medical centers continue to depend on voluntary reporting to track institutional safety, despite repeated studies showing the inadequacy of such reporting."[293]

- **Texas**. According to a 2009 investigative series by Hearst newspapers,[294] after Texas enacted its cap on non-economic damages, "the number of complaints against Texas doctors to the Medical Board rose from 2,942 to 6,000 in one year. More than half of those complaints were about the quality of medical care."[295] Yet, "Texas has fumbled attempts to establish a medical error reporting system, often leaving patients to discover errors the hard way — when a mistake costs them their livelihood or the life of a loved one."[296] "In 2003, Texas hospitals were asked to report just nine broadly defined error categories. The Texas data kept from 2003 to 2007 kept hospital names secret. Only error totals were made available to the public."[297] The data on the Texas Department of State Health Services' Web site is minimal and suspiciously low and "[f]amilies of patients found the general nature of the reporting infuriating."[298] What's more, in 2003, "the Texas lawmakers established the fledgling Office of Patient Protection, designed to respond to complaints from the public not handled by the Medical Board."[299] But, "it never got the chance to work. The Legislature eliminated the agency in 2005 and, without resistance from the hospital lobby, eliminated the error reporting system in 2007."[300]

- **Washington.** The Hearst investigation found that, thousands are "harmed each year by medical care in Washington hospitals, some fatally and some suffering serious disabilities" and that even "[t]hough Washington is one of 27 states that require hospitals and other facilities to report serious medical errors, just a fraction [of] the errors that

likely happen here are reported."[301] "[T]here are likely at least 2,200 reportable incidents a year in Washington."[302] In 2009, facilities reported only 198 to the Washington health department.[303] "Washington's medical error reporting program isn't able to enforce the reporting law because it's underfunded and lacks enforcement powers – and because the rules laying out which incidents must be reported make it easy for hospitals to rule that an error isn't a 'reportable error.'"[304] "Nearly 7,000 patients spent 29,000 days at Yakima Regional last year; it is one of the largest facilities in the state that hasn't filed any adverse event reports since the law went into effect in June 2006."[305] "Washington's 162 walk-in surgery centers were added to the list of facilities required to report this year. In the first two quarters of 2010 only four of them have reported a total of five adverse events. Experts say that number is also incredibly low based on the volume of work being done in these facilities, which do more than 340,000 surgical procedures each year."[306]

❖ MOST PATIENTS WORRY ABOUT MEDICAL ERRORS.

Wolters Kluwer Health Survey, 2012.

- "Nearly three-quarters [73 percent] of patients say they are concerned about the potential for medical errors, according to a poll that sheds light on public perceptions of patient safety."[307]

- "Three in 10 patients said they had experience with a medical error, either personally or through a close friend or family member."[308]

- "Twenty-one percent reported having been misdiagnosed by a physician…."[309]

❖ PATIENT SAFETY IS SUFFERING BECAUSE SO FEW INJURED PATIENTS SUE.

"The Empirical Effects of Tort Reform," Cornell University Law School Professor Theodore Eisenberg, 2012.

> "One possible factor contributing to the continued high rate of errors is that doctors do not expect to bear the full cost of harms caused by their negligence. Studies of medical error consistently find that the vast majority of patients injured by medical error do not file a claim (Weiler et al. 1993; Sloan et al. 1995; Andrews, 2006). Those that do sue often do not recover. Beyond this, hospitals do not bear the full costs of the harms caused in them even though hospitals directly and indirectly influence patients' risk of medical error (Mello et al. (2007))."[310]

The Medical Malpractice Myth, University of Pennsylvania Law School Professor Tom Baker, 2005.

> "[T]here are far more cases of medical malpractice than medical malpractice litigation. Professor Danzon reported that there were 10 incidents of medical malpractice for every one malpractice claim in the United States. The Harvard group found a seven-to-one ratio in New York and Colorado and a five-to-one ratio in Utah. Because hospital record reviews miss so much medical malpractice, the real multiple is much higher.
>
> …
>
> "[T]he Harvard team looked at about 30,000 hospital records in New York and found conclusive evidence of a serious injury from medical malpractice in the records of 280 patients. How many of those 280 patients brought a claim? Eight. That is less than 3 percent.
>
> "In Utah and Colorado, the team looked at about 15,000 hospital records and found conclusive evidence of a serious injury from medical malpractice in the records of 161 patients. How many of those 161 patients brought a claim? Four. That is also less than 3 percent."[311]

Empirical Studies, National Center for State Courts, 2011.

- An October 2011 study found that "[m]ost incoming medical malpractice caseloads are down over the last 10 years."[312] More specifically, from 2000 to 2009, med mal filings fell by 18 percent in the general jurisdiction courts of 7 states reporting.[313] In 5 of those states, filings fell by between 18 and 42 percent.[314] These findings are consistent with an April 2011 National Center for State Courts report, which concluded that "[c]ontrary to

the claims of some tort reform advocates, medical malpractice caseloads have been decreasing over time."[315]

- Moreover, according to that April 2011 report, "despite the widespread prevalence of medical negligence,"[316] in 2008 medical malpractice case filings "represented well under 2 percent of all incoming civil cases, and less than 8 percent of incoming tort cases"[317] in the general jurisdiction courts of 12 states reporting.

❖ LITIGATION IMPROVES PATIENT SAFETY.

"A Dose of Reality for Medical Malpractice Reform," UCLA Law Professor Joanna C. Schwartz, 2012.

> After conducting in-depth interviews and a nationwide survey of those responsible for risk management, claims management and quality improvement in hospitals around the country, Acting UCLA Law Professor Joanna C. Schwartz found that malpractice lawsuits enhance patient safety.[318] As Schwartz explained in an August 2012 study, "malpractice lawsuits are playing an unexpected role in patient safety efforts: as a source of relevant information about medical error. The vast majority of interviewees and survey participants report that their hospitals review legal claims, the information developed during the course of discovery, and closed claims for patient safety lessons."[319] Moreover, "litigation data has proven useful to hospital patient safety efforts. Lawsuits reveal allegations of medical negligence and other patient safety issues about which hospital were previously unaware; depositions and discovery materials surface previously unknown details of adverse events; analyses of claim trends reveal problem procedures and departments; and closed claims files serve as rich teaching tools."[320]

"The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?" University of Illinois Professor of Law and Medicine David A. Hyman and University of Texas Law Professor Charles Silver, 2005.

- The field of surgical anesthesia, where anesthesiologists adopted practice guidelines to reduce deaths, injuries, claims and lawsuits, is a strong case in point. Hyman and Silver write: "[T]wo major factors forced their hand: malpractice claims and negative publicity.… Anesthesiologists worked hard to protect patients *because* of malpractice exposure, not in spite of it."[321]

- As Hyman and Silver explain in a later paper, the reason why tort liability promotes patient safety is obvious: Providers are rational. When injuring patients becomes more expensive than not injuring them, providers will stop injuring patients.[322]

"The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," George J. Annas, J.D., M.P.H., 2006.

> "In the absence of a comprehensive social insurance system, the patient's right to safety can be enforced only by a legal claim against the hospital. … [M]ore liability suits against hospitals may be necessary to motivate hospital boards to take patient safety more seriously.… Anesthesiologists were motivated by litigation to improve patient safety. As a result, this profession implemented 25-years-ago a program to make anesthesia safer for patients and as a result, the risk of death from anesthesia dropped from 1 in 5000 to about 1 in 250,000."[323]

Lifesavers, Center for Justice & Democracy, 2002.

Numerous other medical practices have been made safer only after the families of sick and injured patients filed lawsuits against those responsible. In addition to anesthesia procedures, these include catheter placements, drug prescriptions, hospital staffing levels, infection control, nursing home care and trauma care.[324] As a result of such lawsuits, the lives of countless other patients have been saved.

Harvard Medical Practice Study, 1991.

"[T]he litigation system seems to protect many patients from being injured in the first place. And since prevention before the fact is generally preferable to compensation after the fact, the apparent injury prevention effect must be an important factor in the debate about the future of the malpractice litigation system."[325]

❖ "FEAR OF LITIGATION" IS NOT THE MAIN REASON DOCTORS FAIL TO REPORT ERRORS.

Hospital Incident Reporting Systems Do Not Capture Most Patient Harm, Office of Inspector General, U.S. Department of Health and Human Services, 2012.

> As noted earlier, a January 2012 report from the U.S. Department of Health and Human Services (HHS) found that massive error underreporting at hospitals is caused by widespread employee failure to recognize patient harm.[326] According to the HHS Inspector General, "[T]he problem is that hospital employees do not recognize 'what constitutes patient harm' or do not realize that particular events harmed patients and should be reported. In some cases, he said, employees assumed someone else would report the episode, or they thought it was so common that it did not need to be reported, or 'suspected that the events were isolated incidents unlikely to recur.'"[327]

"Choosing Your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients," University of Washington Internal-Medicine Physician Thomas Gallagher et al., 2006.

> According to a 2006 study published in the *Archives of Internal Medicine*, comparisons of how Canadian and U.S. doctors disclose mistakes point to a "culture of medicine,"[328] not lawyers, for their behavior. In Canada, there are no juries, non-economic awards are severely capped and "if patients lose their lawsuits, they have to pay the doctors' legal bills,"[329] "yet doctors are just as reluctant to fess up to mistakes."[330] Moreover, "doctors' thoughts on how likely they were to be sued didn't affect their decisions to disclose errors."[331] The authors believed "the main culprit is a 'culture of medicine,' which starts in medical school and instills a 'culture of perfectionism' that doesn't train doctors to talk about mistakes."[332]

"The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," George J. Annas, J.D., M.P.H., 2006.

> Research by Annas "found that only one quarter of doctors disclosed errors to their patients,"[333] but "the result was not that much different in New Zealand, a country that has had no-fault malpractice insurance"[334] (*i.e.*, no litigation against doctors) for decades. In other words, "[t]here are many reasons why physicians do not report errors, including a general reluctance to communicate with patients and a fear of disciplinary action or a loss of position or privileges."[335]

❖ "TORT REFORM" INTERFERES WITH PATIENT SAFETY INITIATIVES.

"The Empirical Effects Of Tort Reform," Cornell University Law School Professor Theodore Eisenberg, 2012.

> "Evidence suggests that greater savings to hospitals and insurers can be achieved not at the expense of patient victims. … Caps that reduce premiums by brute force likely discourage more painstaking but socially desirable efforts to improve safety."[336]

CBO's Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice ("Tort Reform"), Congressional Budget Office, 2009.

> The Congressional Budget Office (CBO), in an October 2009 analysis (in the form of a 7-page letter to Senator Orin Hatch), said, "The [medical malpractice] system has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for their losses…."[337] CBO wrote that "imposing limits on [the right to sue for damages] might be expected to have a negative impact on health outcomes." Of the three studies that address the issue of mortality that it examined, CBO noted that one study found tort system restrictions would lead to a .2 percent increase in the nation's overall death rate. If true, that would be an additional 4,874 Americans killed every year by medical malpractice, or 48,740 Americans over the 10-year period CBO examines.[338] Moreover, based on these same numbers, another 400,000 or more patients could be injured during the 10 years that CBO examined (given that one in 10 injured patients die[339]).

NOTES

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[4] Robert C. LaFountain and Cynthia G. Lee, "Medical Malpractice Litigation in State Courts" (April 2011) at 2, www.courtstatistics.org/~/media/Microsites/Files/CSP/Highlights/18_1_Medical_Malpractice_In_State_Courts.ashx
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[6] Richard LaFountain et al., *Examining the Work of State Courts: An Analysis of 2008 State Court Caseloads* (National Center for State Courts 2010) at 26, http://www.ncsconline.org/d_research/csp/2008_files/Civil.pdf.
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[15] *Id.* at 2025, 2031.
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[42] *Ibid*.
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executive of a non-profit hospital and as vice president of a major university teaching hospital. The article was funded by a grant from CJ&D and has been submitted for publication.
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[136] *Ibid* (citation omitted). According to Hyde, "Malpractice insurance has been an extremely difficult issue for Pennsylvania physicians and hospitals in the time period (1994 to present) since the Office of Technology Assessment dismissed 'defensive medicine' as a minor, even illusory issue. That is, in part, because physicians and hospitals indulged in the self-insurance business, through the now insolvent MIIX and Hospital Association of Pennsylvania misadventures. Commercial insurers often avoid markets where 'home grown' and 'provider owned' insurance is their competitor. As a result of these insurance problems, Pennsylvania has compelled a variety of taxes and insurance surcharge premiums for purposes of providing affordable malpractice insurance coverage. Quite aside from the limitations of studies in this area, the controversies stemming from insurance problems facing Pennsylvania physicians and hospitals – some self-inflicted – would color and may overshadow any attempt to generalize findings from that state." *Id.* at 2.
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