MEDICAL LIABILITY REFORM: CUTTING COSTS, SPURRING INVESTMENT, CREATING JOBS

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BEFORE THE

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MEDICAL LIABILITY REFORM: CUTTING COSTS, SPURRING INVESTMENT, CREATING JOBS

THURSDAY, JANUARY 20, 2011

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Committee met, pursuant to notice, at 10:30 a.m., in room 2141, Rayburn House Office Building, the Honorable Lamar Smith (Chairman of the Committee) presiding.

Present: Representatives Smith, Sensenbrenner, Coble, Gallegly, Goodlatte, Lungren, Chabot, Forbes, King, Franks, Gohmert, Poe, Chaffetz, Reed, Griffin, Marino, Gowdy, Ross, Adams, Quayle, Conyers, Nadler, Scott, Watt, Jackson Lee, Waters, Johnson, Pierluisi, Quigley, Deutch, Sánchez, and Wasserman Schultz.

Staff Present: (Majority) Allison Halataei, Counsel; Paul Taylor, Counsel; and Perry Apelbaum, Minority Staff Director and Chief Counsel.

Mr. SMITH. The Judiciary Committee will come to order.

Welcome everybody. I appreciate the Members who are here, as well as our witnesses. And it is nice to see so many people in the audience interested in such an important subject, as well.

One quick announcement, I think as most Members know but not everybody else may know, is that we are expecting votes in about 15 minutes. However, we are only having two votes, so we will be taking a recess for about 20 minutes but then we will return to resume the hearing.

I am going to recognize myself for an opening statement, then turn to the Ranking Member for his opening statement, as well.

The purpose of this hearing is to discuss the need to reduce the waste in our health-care system caused by defensive medicine. This practice occurs when doctors are forced by the threat of lawsuits to conduct tests and prescribe drugs that are not medically required.

According to a Harvard University research study, 40 percent of medical malpractice lawsuits filed in the United States lack evidence of medical error or any actual patient injury. But because there are so many lawsuits, doctors are forced to conduct medical tests simply to avoid a possible lawsuit.

Taxpayers pay for this wasteful defensive medicine, which adds to all of our health-care costs without improving the quality of patient care.

A survey released last year found defensive medicine is practiced by nearly all physicians. President Obama, himself, acknowledged the harm caused by defensive medicine, stating, quote, "I want to work to scale back the excessive defensive medicine that reinforces our current system and shift to a system where we are providing better care rather than simply more treatment," end quote.

Yet the health-care legislation he signed does nothing to prevent defensive medicine. In fact, it makes matters worse by allowing trial lawyers to opt out of any alternatives to health-care litigation proposed by the States and by exposing doctors to even more lawsuits if they fall short of any of the many new Federal guidelines the law creates. The encouragement of lawsuit abuse will not only make medical care much more expensive, it will also drive more doctors out of business.

The Judiciary Committee will consider alternative health-care lawsuit reforms modeled on California's reforms, which have been in effect for over 30 years. Those reforms have a proven record of reducing defensive medicine, reducing health-care costs, and increasing the supply of doctors.

There is a clear need for reform at the Federal level. Many state Supreme Courts have nullified reasonable litigation management provisions enacted by State legislatures. In such States, passage of Federal legislation by Congress may be the only means of addressing the State's current crisis in medical professional liability and restoring patients' access to quality health care.

Further Federal legislation is needed to stem the flow of doctors from one State to another, as they flee States to avoid excessive liability cost. Doctors should feel free to practice medicine wherever they want, and patients everywhere should be able to obtain the medical care they need.

Last year, the Congressional Budget Office determined that a legal reform package would reduce the Federal budget deficit by an estimated $54 billion over the next 10 years, and that was a conservative estimate. Another CBO report estimates that premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law.

The Government Accountability Office has found that rising litigation awards are responsible for skyrocketing medical professional liability premiums. Its report states that the GAO found that "losses on medical malpractice claims, which make up the largest part of insurers' cost, appear to be the primary driver of rate increases in the long run," end quote. The GAO also concluded that insurer profits, "are not increasing, indicating that insurers are not charging and profiting from excessively high premium rates."

The National Commission on Fiscal Responsibility and Reform, which was created by President Obama, also supports health-care litigation reform in its 2010 report. "Many members of the Commission also believe that we should impose statutory caps on punitive and noneconomic damages, and we recommend that Congress consider this approach and evaluate its impact."

As a USA Today editorial concluded, one glaring omission from the health-care law was the significant tort reform, which was opposed by trial lawyers.

I look forward to hearing from our witnesses today, who will help us assess the extent of the current health-care litigation cost.

And I am now pleased to welcome the remarks of the Ranking Member, Congressman John Conyers.

[The prepared statement of Mr. Smith follows:]

Statement of Judiciary Committee Chairman Lamar Smith
Hearing on "Medical Liability Reform – Cutting Costs, Spurring Investment, Creating Jobs"
January 20, 2011
(Final)

I've called this hearing to discuss the need to reduce the waste in our health care system caused by so-called "defensive medicine." This practice occurs when doctors are forced by the threat of lawsuits to conduct tests and prescribe drugs that aren't medically required.

According to a Harvard University research study, 40% of medical malpractice lawsuits filed in the United States lack evidence of medical error or any actual patient injury. But because there are so many lawsuits, doctors are forced to conduct medical tests simply to avoid a lawsuit in which lawyers claim "everything possible" was not done for a patient.

Taxpayers pay for this wasteful defensive medicine, which adds to all our health care costs without improving the quality of patient care.

A survey released last year found defensive medicine is practiced by all physicians. The results, published in the *Archives of Internal Medicine*, found that 91% of doctors "reported believing that physicians order more tests and procedures than needed to protect themselves from malpractice suits."

President Obama himself acknowledged the harm caused by defensive medicine, stating "I want to work [to] scale back the excessive defensive medicine that reinforces our current system, and shift to a system where we are providing better care, simply -- rather than simply more treatment."

Yet the health care legislation he signed does nothing to prevent defensive medicine. In fact, it makes matters worse by allowing trial lawyers to opt out of any alternatives to health care litigation proposed by the states, and by exposing doctors to even more lawsuits if they fall short of any of the many new federal guidelines the law creates.

This encouragement of lawsuit abuse will not only make medical care much more expensive; it will drive more doctors out of business.

The Judiciary Committee will consider alternative health care lawsuit reforms modeled on California's reforms, which have been in effect for over 30 years. Those reforms have a proven record of reducing defensive medicine, reducing health care costs, and increasing the supply of doctors.

There is a clear need for reform at the federal level. Many State supreme courts have judicially nullified reasonable litigation management provisions enacted by State legislatures that sought

to address the crisis in medical professional liability that reduces patients' access to health care.

In such States, passage of federal legislation by Congress may be the only means of addressing the State's current crisis in medical professional liability and restoring patients' access to health care.

Further, federal legislation is needed to stem the flow of doctors from one state to another, as they flee states to avoid excessive liability costs. Doctors should feel free to practice medicine wherever they want, and patients everywhere should be able to obtain the medical care they need.

Republican-proposed reforms are more widely supported today than ever. Last year, the Congressional Budget Office (CBO) determined that a legal reform package modeled on Republican-supported reforms would reduce the federal budget deficit by an estimated $54 billion over the next 10 years.

Another CBO report estimates that "under [Republican-proposed reforms], premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law."

The Government Accountability Office (GAO) has found that rising litigation awards are responsible for skyrocketing medical professional liability premiums. Its report states that "GAO found

that losses on medical malpractice claims – which make up the largest part of insurers' costs – *appear to be the primary driver of rate increases in the long run* ..."

The GAO also concluded that insurer profits "are not increasing, indicating that insurers are not charging and profiting from excessively high premium rates."

The National Commission on Fiscal Responsibility and Reform, which was created by President Obama, also supports health care litigation reform in its 2010 report:

> **Many members of the Commission also believe that we should impose statutory caps on punitive and non-economic damages, and we recommend that Congress consider this approach and evaluate its impact.**

All these recommended reforms are included in Republican-supported reforms.

As a *USA Today* editorial concluded, "one glaring omission" from the Democrats' health care law "was significant tort reform, which was opposed by trial lawyers and their Democratic allies.

I look forward to hearing from all our witnesses today, who will help us assess the nature of the current health care litigation crisis.

Mr. CONYERS. Thank you, Chairman Smith and Members.

This is our first hearing in the 112th session. And I would like to just add for your consideration my recommendations that we review, in connection with health care, the antitrust exemption that health insurance companies enjoy, the McCarran-Ferguson exemption, and that the Sunshine Litigation Act that ensures and prevents secret settlements from being used to endanger the public safety or shield those who may be guilty of fraudulent acts, includ-

ing the medical community, that, in turn, would protect all patients and protect professionally responsible doctors from abuse of claims of wrongdoing.

And then you remember the act that me and a former Member, Campbell, introduced that empowers doctors to negotiate an even playing field with health insurers.

So I would like us to kindly consider those measures that might be more important than an oversight hearing on a subject matter that Members of Congress have already announced that they are going to introduce, namely H.R. 5, which I expect will be coming down the pike one day next week. The letters are already circulating on it.

And so I find that an oversight hearing for a bill that is being written to be the subject will come straight to our Committee. It isn't exactly reverse, but there is a certain irony in the way this is coming off today, and I just wanted to put it in the record.

Now, legislative hearings should be held prior to the oversight hearings. But, also, I hope that we can get into the issue of the shortage of doctors in rural areas, which is critical and which many of us view would be increased by a cap on medical liability, this $250,000 cap. Most of our witnesses here today realize that that may have a perverse effect before it is all over with.

Now, about the large number of cases filed, one out of every eight cases filed ever results in a lawsuit. And that is because, with the statute of limitations, attorneys have to include in the filings many people who may not be involved and are usually excluded from any trial liability but they get counted as the ones that are sued. So I am looking forward to a discussion about that.

Now, we have States that constitutionally preclude any limitation on Medicare damages. Kentucky and Iowa limit the damages. Dr. Hoven is from Kentucky; Dr. Weinstein is from Iowa. And Kentucky is one of the four States that constitutionally prohibit limits on damages. But there are other States—Arizona, Pennsylvania, Wyoming, including the trauma center that provided such excellent care to our colleague, Gabby Giffords, are all, I think, under some danger presented by some of the trends that we are expecting in H.R. 5. And I think that is something we ought to consider.

I close with just a comment about the real cost of medical malpractice claims. They are only a fraction of the real cost. And I end on this note. The sixth-largest cause of death in the United States of America, medically, are malpractice cases.

And so I hope that, as this discussion rolls out this morning, we will be considering what we do with the hundreds of thousands of people that could be adversely affected, whose lifetime costs—even though they are innocent and the case is supported by the court and judgments are entered, but with a $250,000 cap, as many of us know on all the hearings we have had prior to now, that this would be very minimal, indeed.

And I thank you for the time.

Mr. SMITH. I thank the Ranking Member for his comments.

We are now going to take a short recess so Members may vote. When we return, I will recognize the Chairman and Ranking Member of the Constitutional Law Subcommittee for their opening

statements. They have jurisdiction over this particular issue. And then we will get to our witnesses.

So we stand in recess until about 20 minutes from now.

[Recess.]

Mr. SMITH. The Committee will resume our hearing.

And I will now recognize the Chairman of the Constitutional Law Subcommittee, the gentleman from Arizona, Mr. Franks, for his opening statement. And then we will go to the Ranking Member of the Constitutional Law Subcommittee.

Mr. FRANKS. Well, thank you, Mr. Chairman.

Mr. Chairman, the medical liability litigation system in the United States, I think, by all accounts, is broken and in desperate need of reform. The current system is as ineffective a mechanism for adjudicating medical liability claims as it can be, which leads to increased health-care costs, unfair and unequal awards for victims of medical malpractice, and reduced access to health care for all Americans.

Only reforms to the system at the Federal level can address the current national medical liability crisis. Unfortunately, the massive health-care overhaul that President Obama signed into law last year did not meaningfully address medical liability reform. Thus, we are here today to examine this continuing problem and evaluate national solutions to this, what I believe to be a crisis.

One of the largest drivers of this crisis is the practice of defensive medicine. Defensive medicine leads doctors to order unnecessary tests and procedures—not, Mr. Chairman, to ensure the health of the patient, but out of fear of malpractice liability.

The cost of defensive medicine is, indeed, staggering. According to a 2003 Department of Health and Human Services report, the cost of defensive medicine is estimated to be more than $70 billion annually. Additionally, medical liability litigation increases the cost of health care by escalating medical liability insurance premiums. This, in turn, of course, leads to higher costs throughout the entire health-care system and reduces access to medical services.

However, Mr. Chairman, despite the increased costs medical liability litigation imposes, this litigation fails to accomplish its ostensible purpose, the goals of tort law in the first place, and that is fairly compensating the victims and deterring future negligence.

The system fails to compensate victims fairly for several reasons. First, according to the studies, the vast majority of incidents of medical negligence do not result in a claim, and most medical practice claims exhibit no evidence of malpractice. So, victims of malpractice, or most of them, go uncompensated, and most of those who are compensated are not truly victims.

Mr. Chairman, medical malpractice awards vary greatly from case to case, even where the claims and injuries are virtually identical. And, finally, attorneys regularly reduce damages awarded to victims by more than 40 percent through fees and costs.

Moreover, there appears to be little evidence to suggest that the current medical liability system deters negligence. Rather, the available evidence seems to suggest that the threat of litigation causes doctors not to reveal medical errors and to practice defensive medicine. And this, of course, subjects patients to unnecessary tests and treatments once again.

So we must reform the medical liability system in the United States, Mr. Chairman. Among other benefits, reform could do some of the following. It could lead to a significant savings on health care; it could reduce the practice of defensive medicine; halt the exodus of doctors from high-litigation States and medical specialties; improve access to health care; and save the American taxpayers billions of dollars annually while increasing the affordability of health insurance.

Mr. Chairman, meaningful medical liability reforms have worked in States such as California and Texas, and it is time for action at the Federal level to extend the benefits of reform to all Americans.

And I thank you for the time and yield back.

Mr. SMITH. Thank you, Mr. Franks.

The gentleman from New York, Mr. Nadler, the Ranking Member of the Constitutional Law Subcommittee, is recognized for his opening statement.

Mr. NADLER. Thank you, Mr. Chairman.

Mr. Chairman, I had not prepared an opening statement because I didn't know that we were going to have opening statements for Rankings and the Chairmen of the Subcommittees, but I will make an opening statement nonetheless.

I have always believed that this problem is the wrong problem and it is a solution in search of a problem.

If you look at the evidence over many years—and I have looked at the evidence in 1986 consideration of reforms to this problem in the New York State assembly when I was a member there, so I have been involved with this off and on for 25 years—you find that the real problem is not the excessive cost of malpractice—or that the excessive cost of malpractice insurance is not caused by lack of the so-called tort reforms that are being advanced here and that have been advanced over the years—namely, making it harder to get attorneys, capping fees, or capping recoveries—that capping these recoveries would simply be unfair to people who are very seriously injured.

First of all, we know that most people who suffer real damage as a result of medical negligence never sue. So the amount of recovery is very small compared to the amount of cost.

Secondly, study after study has found that the real problem is that the States—and some people might say the Federal Government should do it, but that is a separate discussion—but the States, in any event, whose job it is under current law, are not disciplining doctors, that something like 90 or 95 percent of the claims dollars that are awarded come from 2 or 3 percent of the doctors. Those 2 or 3 percent of the doctors are hurting patients, killing patients, and should not be practicing medicine. They should be stripped out of practice. And if they did, everybody else's malpractice premiums would go down because the amount of costs would go way down, and the other 97 or 98 percent of doctors would find their malpractice premiums much reduced.

Now, what do we find from the kinds of proposals that we consider? Number one, in May 2009, WellPoint, a major malpractice insurer, said that liability was not driving up health insurance premiums.

An economist at Harvard University, Amitabh Chandra, in an article, "Malpractice Lawsuits are 'Red Herring' in Obama Plan," published by Bloomberg in June of last year, concluded that, quote, "Medical malpractice dollars are a red herring" for the system's failures. "No serious economist thinks that saving money in med mal is the way to improve productivity in the system. There are so many other sources of inefficiency."

We know that preventable medical errors kill as many as 98,000 Americans each year, at a cost of $29 billion, and these proposals would do nothing about that.

We are told that the defensive medicine is costing us huge amounts of money and increasing the cost of the medical system as a whole. And yet the GAO, the Government Accountability Office, issued a statement saying, quote, "The overall prevalence and costs of [defensive medicine] Have not been reliably measured," so we don't really know. "Studies designed to measure physicians' defensive medicine practices examined physician behavior in specific clinical situations, such as treating elderly Medicare patients with certain heart conditions. Given their limited scope, the study results cannot be generalized to estimate the extent and cost of defensive medicine practices across the health-care system," unquote.

Multiple GAO studies have concluded that eliminating defensive medicine would have only a minimal effect on reducing overall health-care costs.

But the proposals that I assume we will have before us, which are the proposals that are introduced by our colleagues on the other side of the aisle every single year, all have in common putting a $250,000 limit on noneconomic damages—that is to say, on damages other than direct medical costs and lost wages, which may be the main damages for someone whose wages you can't measure, like a college student or a child because you don't know what his wages are going to be or would have been.

But $250,000 is not very much. Now, MICRA in California was enacted in 1976, and they felt that $250,000 was a reasonable amount then. In today's dollars—or, rather, in 1975 dollars, that is now worth $62,000. Would they have enacted a $62,000 cap in 1975? And if we wanted to take their $250,000 and inflate it to keep it at the same value, it would be over a million dollars today. So if we are going to pass this kind of legislation, which I hope we won't, at the least we should put in an inflation factor and start at a million dollars if we want to duplicate what MICRA did in California.

And, of course, in California, MICRA did not reduce the premiums at all. They went up, from 1975 to 1988, by 450 percent. Only after insurance reform was enacted in 1988 by California did the insurance premiums level off and actually go down a bit. For the 13 years—a perfect experiment—for the 13 years during which California had the tort reform but not the insurance reform, the premiums went up 450 percent. When the insurance reform was enacted, premiums went down 8 percent. So maybe we should be talking about insurance reform instead of tort reform. But, unfortunately, that is not in front of his Committee.

So I think we are off on the wrong track if we are concentrating on this. And I see the red light is on. I apologize for exceeding my time, and I yield back whatever time I don't have left.

Mr. SMITH. Thank you, Mr. Nadler.

And, without objection, other Members' opening statements will be made a part of the record. And now I will introduce our witnesses.

And our first witness is Dr. Ardis Hoven, chair of the American Medical Association Board of Trustees. Prior to her election to the board, Dr. Hoven served as a member and chair of the AMA Council on Medical Service. She was a member of the Utilization Review and Accreditation Commission for 6 years and served on its executive committee. Most recently, she was appointed to the National Advisory Council for Healthcare Research and Quality.

We welcome you.

Our second witness is Joanne Doroshow, executive director of the Center for Justice and Democracy. Ms. Doroshow is the founder of the Center for Justice and Democracy and cofounder of Americans for Insurance Reform. She is an attorney who has worked on issues regarding health-care lawsuits since 1986, when she directed an insurance industry and liability project for Ralph Nader.

Welcome to you.

Our third witness is Dr. Stuart L. Weinstein, a physician spokesman for the Health Coalition on Liability and Access. Dr. Weinstein is a professor of orthopedic surgery and professor of pediatrics at the University of Iowa. He is a former chair of Doctors for Medical Liability Reform.

And we welcome you, as well.

Just a reminder, each of the witnesses' testimonies will be made a part of the record. We do want you to limit your testimony to 5 minutes. And there is a light on the table that will indicate by its yellow light when you have 1 minute left, and then the red light will come on when the 5 minutes is up.

So we look forward to your testimony, and we will begin with Dr. Hoven.

TESTIMONY OF ARDIS D. HOVEN, M.D., CHAIR, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. HOVEN. Thank you, and good morning, Chairman Smith, Ranking Member Conyers, and Members of the Committee on the Judiciary. As stated, I am Dr. Ardis Hoven, chair of the American Medical Association Board of Trustees and a practicing internal medicine physician and infectious disease specialist in Lexington, Kentucky.

On behalf of the AMA, thank you for holding this hearing today to talk about this very important issue.

This morning, I will share with you results from AMA studies that prove how costly and how often unfair our medical liability system is to patients and physicians. Most importantly, I will talk about a solution. That solution is a package of medical liability reforms based on reforms that have already been proven effective in States like California, Texas, and Michigan.

Our current medical liability system has become an increasingly irrational system, driven by time-consuming litigation and open-

ended, noneconomic damage awards that bring instability to the liability insurance market. It is also an extremely inefficient mechanism for compensating patients harmed by negligence, where court costs and attorney fees often consume a substantial amount of any compensation awarded to patients.

Let me share with you some of the alarming statistics from an August 2010 AMA report that shows how lawsuit-driven our system has become.

Nearly 61 percent of physicians age 55 and older have been sued. Before they reach the age of 40, more than 50 percent of obstetricians/gynecologists have already been sued. And 64 percent of medical liability claims that closed in 2009 were dropped or dismissed. These claims are clearly not cost-free. And let's also not forget the emotional toll on physicians and their patients involved in drawn-out lawsuits, which is hard to quantify.

Out of fear of being sued, physicians and other health-care providers may take extra precautionary measures, known as "the practice of defensive medicine." A 2003 Department of Health and Human Services report estimated the cost of the practice of defensive medicine to be between $70 billion and $126 billion per year. Every dollar that goes toward medical liability costs is a dollar that does not go to patients who need care, nor toward investment in physician practices, a majority of which are small businesses that create jobs that benefit local and State economies.

The good news is there are proven examples of long-term reforms that have kept physicians' liability premiums stable, but, more importantly, have insured and protected patients' access to health care.

Back in 1974, California was experiencing many of the problems we are facing today. In response, California's legislature enacted a comprehensive package of reforms called the Medical Injury Compensation Reform Act of 1975 over 35 years ago, which is now commonly referred to as "MICRA."

While total medical liability premiums in the rest of the U.S. rose 945 percent between 1976 and 2009, the increase in California premiums was less than one-third of that at just about 261 percent.

Recent public polls found that a majority of Americans support reasonable limits on noneconomic damages and believe that medical liability lawsuits are a primary reason for rising health-care costs.

We look forward to the introduction of the HEALTH Act that mirrors California's reforms and also protects current and future medical liability reforms at the State level.

By supporting patients' safety initiatives alongside enacting meaningful medical liability reform like the HEALTH Act, Congress has the opportunity to protect access to medical services, reduce the practice of defensive medicine, improve the patient-physician relationship, support physician practices and the jobs they create, and curb a wasteful use of precious health-care dollars: the costs, both financial and emotional, of health-care liability litigation.

On behalf of the AMA, I would like to extend our appreciation for the leadership of the committee. And the AMA looks forward to

working with you all to pass Federal legislation that would bring about meaningful reforms.

And thank you.

[The prepared statement of Dr. Hoven follows:]

PREPARED STATEMENT OF ARDIS D. HOVEN

Statement

of the

American Medical Association

to the

Committee on the Judiciary
United States House of Representatives

RE: Medical Liability Reform - Cutting Costs, Spurring Investment, Creating Jobs

Presented by Ardis D. Hoven, MD

January 20, 2011

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Statement

of the

American Medical Association

to the
Committee on the Judiciary
United States House of Representatives

RE: Medical Liability Reform - Cutting Costs, Spurring Investment, Creating Jobs

Presented by Ardis D. Hoven, MD

January 20, 2011

The American Medical Association (AMA) appreciates the opportunity to testify before the House Committee on the Judiciary on the need to enact meaningful medical liability reform at the federal level. Growing medical liability system costs are a national problem that requires a national solution. Studies show the litigation system to be an ineffective, and often unfair, mechanism for resolving medical liability claims. We believe that the time is ripe for Congress to enact a federal approach to resolving medical liability cases. The AMA remains committed to proven, effective reforms based on California's successful model, MICRA, (the "Medical Injury Compensation Reform Act of 1975") that includes a $250,000 cap on non-economic damages. We also support additional federal funding to examine alternative approaches to improving the current medical liability system.

The Current Tort System Fails Patients and Physicians and Drives Up Health Care Costs

The medical liability system is in desperate need of reform. It is neither fair nor cost effective in compensating injured patients. It has become an increasingly irrational system driven by time consuming litigation and open-ended non-economic damage awards. It is also an extremely inefficient mechanism for compensating patients harmed by negligence where court costs and attorney fees often consume a substantial amount of any compensation awarded to patients.

A number of reports by the AMA and others show that the litigation system is a costly and often unfair mechanism for resolving medical liability claims. For example, an

August 2010 AMA report[1] revealed the litigious nature of our current liability system. Among physicians surveyed, there was an average of 95 medical liability claims filed for every 100 physicians, almost one per physician. The report also highlighted that:

- Nearly 61 percent of physicians age 55 and over have been sued;
- There is wide variation in the impact of liability claims between specialties. The number of claims per 100 physicians was more than five times greater for general surgeons and obstetricians/gynecologists than it was for pediatricians and psychiatrists;
- Before they reach the age of 40, more than 50 percent of obstetricians/gynecologists have already been sued; and
- Ninety percent of general surgeons age 55 and over have been sued.

A December 2010 AMA report based on data from the Physicians Insurers Association of America (PIAA) highlights other problems with the current liability system. Sixty-four percent of medical liability claims that closed in 2009 were dropped or dismissed. These dropped or dismissed claims are not cost-free. Defense costs on them averaged over $26,000 per claim and in the aggregate these dropped claims accounted for 35 percent of total defense costs. Among tried claims defense costs averaged over $140,000 per claim for defendant victories and over $170,000 for plaintiff victories. Moreover, a 2006 article in the New England Journal of Medicine showed that no error had occurred in 37 percent of medical liability claims. These factors lead to increased costs for physicians, patients, and our health care system overall.

Experts also agree that the practice of defensive medicine adds billions of dollars to our health care costs. Defensive medicine practices include tests and treatments that are performed as precautionary measures that also help to avoid lawsuits. A 2003 Department of Health and Human Services (HHS) report estimated the cost of defensive medicine to be between $70 and $126 billion per year.[2] These costs mean higher health insurance premiums and higher medical costs for all Americans as well as higher taxes. Taxpayers bear a substantial burden, given that one-third of the total health care spending in our country is paid by the federal government through the Medicare and Medicaid Programs. HHS' report also estimated that Medicare spending alone would have been reduced by $17 to $31 billion per year with comprehensive liability reforms, including but not limited to reasonable limits on non-economic damages. Every dollar that goes toward medical liability costs and defensive medicine is a dollar that does not go to patients who need care, nor toward investment in patient safety and quality improvements or health information technology systems.

In December 2009, the Congressional Budget Office estimated that nationwide implementation of medical liability reforms, including caps on non-economic damages,

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[1] http://www.ama-assn.org/ama1/pub/upload/mm/363/prp-201001-claim-freq.pdf.

[2] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care 11 (2003).

would reduce total U.S. health care spending by about 0.5 percent, or $11 billion, in 2009, and that these reforms would reduce federal budget deficits by $54 billion over the next 10 years.[3] In December 2010, the National Commission on Fiscal Responsibility and Reform released its report on recommendations to bring federal spending and the deficit under control, and they included medical liability reforms as part of a solution to reduce the federal budget deficit.[4] Multiple studies and surveys prove that the U.S. needs a better system for patients and physicians. Our nation's current litigious climate hurts patients' access to physician care at a time when the nation is working to reduce unnecessary health care costs.

Numerous studies show that physicians bring a significant economic value to the communities where they practice medicine. Not only are physicians medical professionals, but their practices typically operate as small businesses. As with any small business, physician practices generally do not have the economic and other resources necessary to absorb or shift the cost of rapidly increasing insurance premiums. When overhead expenses increase, physicians must either increase fees or cut other expenses just to sustain their practices. For physicians, raising fees is becoming more difficult as Medicare, Medicaid, and managed health care plans arbitrarily limit payments for services rendered to patients. Alternatively, if physicians are forced to trim expenses, they are generally limited in their options and must make difficult choices, such as cutting staff, limiting staff benefits (e.g., health insurance), or forgoing the hiring of additional staff or the purchasing of advanced medical equipment. In some cases, physicians must limit certain aspects of their practice in order to find or afford medical liability insurance. For example, numerous family physicians are no longer delivering babies because it is cost prohibitive to insure that component of their practice, and specialists are declining to take call in the emergency department. A comprehensive set of medical liability reforms that brings predictability and stability to the liability insurance market will benefit physician practices, which play an important role as small businesses that support jobs and contribute to local and state economies.

Comprehensive Medical Liability Reforms Work

California

The AMA strongly supports federal legislation based on California's MICRA, which proves that comprehensive liability reform works. Enacted in 1975 by overwhelming bipartisan support, MICRA was in response to a significant increase in medical liability costs and the resulting shortage of health care physicians and providers. MICRA has been held up as "the gold standard" of tort reform, and a model for repeated attempts at federal reform legislation. A study by the RAND Corporation showed that MICRA was successful at decreasing insurer payouts and redistributing money from trial lawyers to injured patients. MICRA's contingency fee reform and limit on non-economic damages caused plaintiff attorney fees to be reduced 60 percent. Also, according to the National Association of Insurance Commissioners, while total medical liability insurance

[3] http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf.
[4] http://www.fiscalcommission.gov/.

premiums in the rest of the U.S. rose 945 percent between 1976 and 2009, the increase in California premiums was less than one third of that amount (261 percent). The major provisions in MICRA that would benefit patients, physicians, and the health care system as a whole include:

- Awarding injured patients unlimited economic damages (e.g., past and future medical expenses, loss of past and future earnings, etc.);
- Awarding injured patients non-economic damages up to $250,000 (e.g., pain and suffering, mental anguish, etc.);
- Establishing reasonable statute of limitations; and
- Establishing a sliding-scale for attorney contingent fees, therefore maximizing the recovery for patients.

Texas

Texas also provides a compelling example of how successful tort reforms improve patient access to care and reduce escalations in medical liability premiums. In 2003, the Texas legislature enacted comprehensive medical liability insurance reform, which included a "stacked cap" on non-economic damages. Under the Texas law, in addition to recovering unlimited economic damages, an injured patient may recover up to $750,000 in non-economic damages in a health care lawsuit against multiple defendants.[5] The Texas reforms created three separate caps, one for health care providers (including physicians) and two for health care institutions (including hospitals). One cap provides a $250,000 limitation on non-economic damages in lawsuits against all health care providers named as defendants in a lawsuit. For institutions, the Texas law also includes a cap of $250,000 on non-economic damages against any one institution, while also permitting a third cap of $250,000 in those instances where more than one institution is found negligent. As a result of comprehensive liability reforms, Texas has enjoyed a 59 percent higher growth rate in newly licensed physicians in the past two years compared to two years preceding reform. Texas has also added 218 obstetricians in the past six years.[6] All major physician liability carriers in Texas have cut their rates since the passage of liability reforms, most by double-digits, and most physicians practicing in Texas have seen their rates slashed by 30 percent or more.

States like California and Texas succeeded in enacting meaningful medical liability reforms, including strong caps on non-economic damages, while others have tried alternative routes to reduce the cost of defensive medicine and eliminate unnecessary litigation from the system. Research shows that over the long term, patients have greater access to physicians in areas with reforms than in areas without. A 2007 AMA review concluded states with caps have about 5 percent more physicians per capita than states without, but that this may be larger for physicians in high risk specialties.[7]

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[5] On September 13, 2003, Texas voters passed Proposition 12. This ballot initiative amended the state constitution to specifically allow the legislature to enact laws that place limits on non-economic damages in health care liability cases.
[6] http://www.texmed.org.
[7] http://www.ama-assn.org/ama1/pub/upload/mm/363/prp2007-1.pdf.

A Federal Solution is Necessary

An ineffective, inefficient, and costly medical liability system requires a national solution. If it was just a matter of physicians obtaining or affording medical liability insurance in one state, we might agree that a national approach would not necessarily be required. However, the problem goes far beyond physicians and other health care professionals and institutions. The medical liability system has become a serious problem for patients and their ability to access health care services that would otherwise be available to them, including services provided to Medicare and Medicaid patients.

The AMA looks forward to the introduction of and strongly supports the "Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011." This federal legislation includes significant reforms that will help repair our nation's medical liability system, reduce the growth of health care costs, and preserve patients' access to medical care. We believe that the proven reforms contained in the HEALTH Act would help repair the medical liability system, while ensuring that patients who have been injured receive just compensation. This bill provides the right balance of reforms by promoting speedier resolutions to disputes, maintaining access to courts, maximizing patient recovery of damage awards with unlimited compensation for economic damages, while limiting non-economic damages to a quarter million dollars. In addition, the HEALTH Act protects effective medical liability reforms at the state level. Specifically, the bill (a) allows states to keep/adopt greater procedural and substantive protections for physicians than those provided under the HEALTH Act; (b) protects current and future state cap laws on economic, non-economic, and punitive damages regardless of whether the amount is greater or lesser than $250,000; and (c) protects any issue addressed under state law (e.g., standards of care) that is not addressed in the HEALTH Act.

In addition, the AMA supports continued federal funding for states to pursue a wide range of liability and patient safety reforms that compliments comprehensive liability reforms including, early disclosure and compensation programs, safe harbors for the practice of evidence-based medicine, and health courts. The AMA also supports amending the Affordable Care Act (ACA) to indicate that any guideline or standard of care in the new law cannot be used against a physician in a liability claim or lawsuit.

Conclusion

By enacting meaningful medical liability reforms, Congress has the opportunity to increase access to medical services, reduce the defensive practice of medicine, improve the patient-physician relationship, help prevent avoidable patient injury, support physician practices and the jobs that they create, and curb the single most wasteful use of precious health care dollars—the costs, both financial and emotional, of health care liability litigation. The AMA applauds the Committee's continued commitment to repairing America's medical liability system, and looks forward to working with you to pass federal legislation that would bring about meaningful reforms.

Mr. SMITH. Dr. Hoven, thank you.
And Ms. Doroshow?

TESTIMONY OF JOANNE DOROSHOW, M.D., EXECUTIVE DIRECTOR, CENTER FOR JUSTICE AND DEMOCRACY

Ms. DOROSHOW. Thank you, Mr. Chairman, Mr. Conyers, Members of the Committee.

The Center for Justice and Democracy, of which I am executive director, is a national public interest organization that is dedicated to educating the public about the importance of the civil justice system. This is the fourth time I have been asked to testify before a congressional Committee in the last 9 years on this very important subject of medical malpractice, and I am honored to do so.

I also spoke at two different informal hearings, chaired by Mr. Conyers, which featured families, including children, from all over the country, whose lives were devastated as a result of medical negligence. One of those hearings lasted 4 hours, as victim after victim told their stories and pleaded with Congress not to cap damages and enact tort reform. They are all paying rapt attention today from afar, and I will do my best to represent them. But I do hope this Committee decides to hear from them directly, because these families are always the forgotten faces in the debate about how to reduce health-care and insurance costs.

While I understand this is an oversight hearing and we do not know what bills yet may be considered by the Committee, typically the push has been for caps on noneconomic damages and other measures that force patients who are injured by medical negligence or the families of those killed to accept inadequate compensation. Meanwhile, the insurance industry gets to pocket money that should be available for the sick and injured, and they force many to turn elsewhere, including Medicaid, further burdening taxpayers.

And, by the way, with regard to the California situation, rates did not come down in California for doctors until 1988, when insurance regulatory reform was passed. It was not due to the cap.

These measures will also reduce the financial incentive for hospitals to operate safely, which will lead to more costly errors. In fact, when the Congressional Budget Office looked into it, they looked at several studies that looked at the negative health outcomes of tort reform, and one of them found it would lead to a 0.2 percent increase in mortality and the overall death rate in this country. That is another 4,000 killed.

Now, while I cover many issues in my written statement, I want to highlight a few other points.

First of all, there is an epidemic of medical malpractice in this country. It has been over a decade since the Institute of Medicine study finding 98,000 dying in hospitals each year, costing $17 billion to $29 billion, and experts agree there has been no meaningful reduction in medical errors in the United States. In fact, in November, just last November, HHS reported that 1 in 7 hospital patients experience a medical error; 44 percent are preventable.

Second, medical malpractice claims and lawsuits are in steep decline, according to the National Center for State Courts and the insurance industry's own data. Plus, to quote from the Harvard

School of Public Health study that the Chairman mentioned, "Portraits of a medical malpractice system that is stricken with frivolous litigation are overblown, and only be a tiny percentage of med mal victims ever sue." In fact, this is the press release from Harvard, issuing that study, that said, "Study casts doubt on claims that the medical malpractice system is plagued by frivolous lawsuits."

Med mal premiums have been stable and dropping since 2006. And if you read the industry's trade publications, you will find out that insurers so overpriced policies in the early part of the last decade that they still have too much money in reserves and that rates will continue to fall. And this has happened whether or not a State has enacted tort reform.

As far as Texas, health-care costs did not come down when caps passed, at all. Applications for new licenses are only part of the picture. When it comes to physicians engaged in patient care—in other words, considering physicians who retire, leave the State, or stop seeing patients—the data shows that the per capita number has not grown. In fact, the number grew steadily through 2003 and then leveled off. This is not a pattern you would expect if 2003 tort reform law was responsible.

When competing for physicians, Texas is more hampered by the extraordinary size of its uninsured population, which exceeds just about every other State.

In terms of defensive medicine, CBO found that was not pervasive, 0.3 percent, from slightly less utilization of health-care services, but even this is too high. What CBO did not consider, for example, are the burdens on Medicaid when there are no lawsuits or the fact that Medicare and Medicaid have liens and subrogation interests in a judgment, so if the lawsuit can't be brought, they can't be reimbursed. All of these costs need to be added in.

Finally, these bills all ignore the insurance industry's major role in the pricing of medical malpractice insurance premiums, an industry that is exempt from antitrust laws under the McCarran-Ferguson Act. This needs to be repealed.

We need to do more to weed out the small number of doctors responsible for most malpractice and reduce claims, injuries and deaths, and lawsuits.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Doroshow follows:]

PREPARED STATEMENT OF JOANNE DOROSHOW

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STATEMENT OF JOANNE DOROSHOW
EXECUTIVE DIRECTOR, CENTER FOR JUSTICE & DEMOCRACY

BEFORE THE HOUSE COMMITTEE ON THE JUDICIARY

January 20, 2011

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STATEMENT OF JOANNE DOROSHOW
EXECUTIVE DIRECTOR, CENTER FOR JUSTICE & DEMOCRACY

BEFORE THE HOUSE COMMITTEE ON THE JUDICIARY

OVERSIGHT HEARING ON "MEDICAL LIABILITY REFORM - CUTTING COSTS, SPURRING INVESTMENT, CREATING JOBS"

January 20, 2011

Mr. Chairman, members of the Committee, I am Joanne Doroshow, President and Executive Director of the Center for Justice & Democracy, a national public interest organization that is dedicated to educating the public about the importance of the civil justice system.

In addition to our normal work, CJ&D has two projects that are relevant to this discussion today: Americans for Insurance Reform, a coalition of nearly 100 public interest groups from around the country that seeks better regulation of the property casualty insurance industry; and the Civil Justice Resource Group, a group of more than 20 prominent scholars from 14 states formed to respond to the widespread disinformation campaign by critics of the civil justice system.

In addition, I served on the New York State Governor's Medical Malpractice Task Force in 2007 and 2008, which among other things, discussed ways to improve patient safety as the best way to reduce injuries, claims, lawsuits and costs to the system.

It should first be noted that, while we do not have specific legislation on which to comment yet, anything that Congress chooses to enact in this area would overturn traditional state common law and would be an unprecedented interference with the work of state court judges and juries in civil cases. Bills that Congress has considered in the past include across-the-board "caps" on compensation for "non-economic damages" - injuries like permanent disability, disfigurement, blindness, loss of a limb, paralysis, trauma, or pain and suffering.

These tort restrictions apply across the board to all cases, not just "frivolous" cases. Their provisions apply no matter how much merit a case has, or the extent of the misconduct of a hospital, doctor or HMO. They apply regardless of the severity of an injury. For many years, we have assisted families from around the nation who have traveled to Washington, D.C. to voice their strong opposition to bills like this. These families are the forgotten faces in the debate over

how to reduce health care and insurance costs, and I hope that at some point, this Committee decides to hear from them.

Bills that Congress has considered in the past would also undermine our constitutional right to trial by jury. They would limit the power and authority of jurors to decide cases based on the facts presented to them. Many states have found such tort restrictions unconstitutional in their state based on their own state law. They also raise significant federal constitutional problems, as well. As Justice Rehnquist has stated:

> The guarantees of the Seventh Amendment [right to civil jury trial] will prove burdensome in some instances; the civil jury surely was a burden to the English governors who, in its stead, substituted the vice-admiralty court. But, as with other provisions of the Bill of Rights, the onerous nature of the protection is no license for contracting the rights secured by the Amendment.[1]

They also would create new burdens on state and federal deficits. If someone is brain damaged, burned, or rendered paraplegic as a result of health care system negligence but cannot obtain adequate compensation through the tort system, he or she may be forced to turn to taxpayer-funded health and disability programs. In other words, the costs of injuries are not eliminated by enacting "tort reform," but merely shift onto someone else – including the government.

Finally, these bills always ignore the insurance industry's major role in the pricing of medical malpractice insurance premiums – an industry that is exempt from anti-trust laws under the McCarran-Ferguson Act. Repealing this act is critical to stabilizing the medical malpractice insurance market. There are also many other patient safety measures that Congress could be exploring. The best way to reduce death, injuries, claims, lawsuits is to reduce the amount of malpractice itself.

The Jobs Issue. The topic of this oversight hearing includes discussion of how limiting patients' legal rights will lead to job creation. As this Committee knows, medical malpractice litigation has been focus of attack by the insurance industry and medical lobbies for 36 years. Every state in the country has dealt with it. President George W. Bush made this a focus of his administration. This is the fourth time in eight and a half years that I have been asked to testify before a House committee on the issue, including by the Small Business Committee. Yet this is the first time I have ever heard an argument made that limiting patients' rights creates jobs. If it were true, surely we would have heard the argument made at some point in the prior 36 years. In fact, we should have heard it repeatedly. It would be the opinion of respected economists, not just lobbyists, or those who would benefit financially, or those whose work is paid for by "tort reform" groups.[2]

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[1] *Parklane Hosiery Co. Inc. v. Shore*, 439 U.S. 322 (1979) (Rehnquist dissenting).

[2] For example, in 2008, Texans for Lawsuit Reform released a "study" that it paid for, supported by no documentation whatsoever, by Ray Perryman that "shows lawsuit reforms enacted in Texas beginning in 1995 have resulted in $112.5 billion in annual spending in Texas, 499,000 new, permanent jobs and a $2.6 billion increase in state tax revenue giving Texas a resounding competitive advantage in these challenging economic times." According to the *Wall Street Journal*, Mr. Perryman may be skilled at self-promotion, but little else. Here's what others said about him: "'He's the most bought economist in Texas,' says Austin City Council Member Brigid Shea, with whom he butted heads when he testified against proposed environmental regulations there. 'He will produce

"Tort reform" does not create jobs. In 2005, the Economic Policy Institute ("EPI") released a study debunking common myths about the costs of the legal system and its burden on consumers.[3] According to EPI, "There is no historical correlation between the inflated estimates of the costs of the tort system and corporate profits, product quality, productivity, or research and development (R&D) spending. Evidence suggests that the tort system, without the proposed restrictions, has actually been beneficial to the economy in all these areas." Moreover, says EPI, "significant tort law change would be more likely to slow employment growth than to promote it. Endlessly repeating that so-called 'tort reform' will create jobs does not make it true."

OVERVIEW: THE STATE OF MEDICAL LIABILITY, MALPRACTICE INSURANCE AND HEALTH CARE

Since the first time I testified in 2002 before the Judiciary Committee's Subcommittee on Commercial and Administrative Law, much has happened in the area of medical malpractice.

THE MEDICAL MALPRACTICE EPIDEMIC

- **The amount of malpractice in U.S. hospitals has grown at alarming rates.**
    - It has been over a decade since the Institute of Medicine's seminal study "To Err is Human"[4] was published, and experts agree a meaningful reduction in medical errors has not occurred in the United States. According to a November 2010 study by the Office of Inspector General of the U.S. Department of Health and Human Services about 1 in 7 hospital patients experience a medical error, 44 percent of which are preventable. These errors cost Medicare $4.4 billion a year.[5] Moreover, "These Medicare cost estimates do not include additional costs required for follow-up care after the sample hospitalizations."[6] The study concludes, "Because many adverse events we identified were preventable, our study confirms the need and opportunity for hospitals to significantly reduce the incidence of events."[7]
    - Also in November 2010, a statewide study of 10 North Carolina hospitals, published in the New England Journal of Medicine, found that harm resulting from medical care

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any conclusion you want,' [and] 'He's got all these computer models he can never explain,' says Austin lawyer Bill Bunch, ... 'It's just this black box. Hocus-pocus,' [and] 'Go to an American Economics Association meeting and ask who Ray Perryman is. Nobody will have ever heard of him,' says Thomas Saving, chairman of the economics department at Texas A&M. The president of the AEA, the major trade group for academic economics, has never heard of Dr. Perryman, a spokeswoman says. Laura Johannes, Economist Ray Perryman Is Hailed As a Genius -- for Self Promotion, *Wall Street Journal*, May 10, 1995.

[3] http://www.epi.org/publications/entry/bp157/

[4] *To Err Is Human, Building a Safer Health System*, Institute of Medicine, 1999. This study found that between 44,000 and 98,000 patients are killed in hospitals each year due to medical errors.

[5] U.S. Department of Health and Human Services, Office of the Inspector General, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (November 2010), pp. i-ii, found at http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.

[6] *Id* at ii-iii (emphasis in original).

[7] *Id* at iii.

was common, with little evidence that the rate of harm had decreased substantially over a 6-year period ending in December 2007. This is considered significant nationally because North Carolina is touted as a leader in efforts to improve safety.[8]

- The situation is probably even worse because 23 states have no medical-error detection program, and even those with mandatory programs miss a majority of the harm."[9] "Most medical centers continue to depend on voluntary reporting to track institutional safety, despite repeated studies showing the inadequacy of such reporting."[10]
- Texas is a good example. According to a 2009 investigative series by Hearst newspapers and the *Houston Chronicle* called "Dead By Mistake",[11] 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." 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. … 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." 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." 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." 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."

CLAIMS AND LAWSUITS

- **While medical errors, the U.S. population and the number of doctors are steadily increasing[12], medical malpractice claims and lawsuits are droppiug significantly.**

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[8] Christopher P. Landrigan et al., "Temporal Trends in Rates of Patient Harm Resulting from Medical Care," *N Engl J Med* 2010; 363:2124-2134, 2130 (November 2010)(citations omitted), found at http://www.nejm.org/doi/full/10.1056/NEJMsa1004404#t=articleTop.

[9] Cathleen F. Crowley and Eric Nalder, "Year after report, patients still face risks," *Times Union*, September 20, 2010, found at http://www.timesunion.com/local/article/Year-after-report-patients-still-face-risks-665059.php#page-1.

[10] Christopher P. Landrigan et al., "Temporal Trends in Rates of Patient Harm Resulting from Medical Care," *N Engl J Med* 2010; 363:2124-2134, 2130-2131(November 2010)(citations omitted), found at http://www.nejm.org/doi/full/10.1056/NEJMsa1004404#t=articleTop.

[11] See, http://www.chron.com/deadbymistake/; Terri Langford, "Texas laws are vague, abandoned or unfunded," *Houston Chronicle*, July 30, 2009.

[12] *Physician Characteristics and Distribution in the U.S.*, American Medical Association. It should be noted that there continues to be physician shortages, but medical malpractice cases have nothing to do with this. For example, according to a recent investigation by the *New York Times* less than one month ago, "More than 42,000 students apply to medical schools in the United States every year, and only about 18,600 matriculate, leaving some of those who are rejected to look to foreign schools. Graduates of foreign medical schools in the Caribbean and elsewhere constitute more than a quarter of the residents in United States hospitals. The New York medical school deans say that they want to expand their own enrollment to fill the looming shortage, but that their ability to do so is impeded

- According to the National Center for State Courts, medical malpractice claims are in steep decline, down 15 percent from 1999 to 2008. The NCSC says rarely does a medical malpractice caseload exceed a few hundred cases in any one state in one year.
- In 2009, our project, Americans for Insurance Reform, took a look at medical malpractice insurance claims, premiums and profits in the country at that time and for 30 years prior. In this report, called "*True Risk: Medical Liability, Malpractice Insurance and Health Care,*"[13] we found that according to the insurance industry's own data, medical malpractice claims, inflation-adjusted, are dropping like a rock, down 45 percent since 2000. 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...."[14]
- The data also show that the amount insurers are paying out in claims has been steadily dropping, as well. In *True Risk*, we found that according to the industry's own data, inflation-adjusted per doctor claims have been dropping since 2002 from $8,676.21 that year to $5,217.49 in 2007 and $4,896.05 in 2008. In fact, at no time during this decade did claims spike, or "explode." Rather, payouts in constant dollars have been stable or falling throughout this entire decade, down 45 percent since 2000. In sum, these data confirm that neither jury verdicts nor any other factor affecting total claims paid by insurance companies that write medical malpractice insurance have had much impact on the system's overall costs.
- In Texas, the non-economic damages cap has a disproportionate impact on the filing of legitimate cases involving children, the elderly and the poor.[15] In a Fall 2008 research paper published in the *Texas Advocate,* professors Charles Silver of the University of Texas School of Law, David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law and Bernard S. Black of the Northwestern University School of Law, estimated that "if the same cases were brought, the cap would result in an 18-25% drop in per-case payouts in settled cases, and a 27% drop in tried cases. We also find that a cap on non-economic damages will have different effects on different groups of plaintiffs, with larger effects on the unemployed and deceased, and likely on the elderly as well. ... [O]ne would expect

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by competition with the Caribbean schools for clinical training slots in New York hospitals. The big Caribbean schools, which are profit-making institutions, are essentially bribing New York hospitals by paying them millions of dollars to take their students. "These are designed to be for-profit education mills to train students to pass the boards, which is all they need to get a license," said Dr. Michael J. Reichgott, a professor at the Albert Einstein College of Medicine in the Bronx. Anemona Hartocollis, Medical Schools in Region Fight Caribbean Flow, *New York Times*, December 22, 2010.

[13] Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009; http://insurance-reform.org/pr/090722.html

[14] "Solid Underwriting Undercut by MPLI's Investment Losses," *Best's Special Report*, A.M. Best, April 27, 2009.

[15] In most cases, lost earnings make up the largest part of the economic damages that go directly to the injured victim. Essentially, then, limiting non-economic damages results in valuing the destruction of an individual's life based on what that person would have earned in the marketplace but for the injury. The lives of low wage earners, children, seniors, and women who do not work outside the home, are thus deemed worth less than the life of businessmen. Capping non-economic damages promotes a kind of caste system by branding entire classes of low- or non-earners in our society as worth less than their wealthier counterparts. It also makes it far less likely that an attorney can afford to bring these cases, providing practical immunity for many wrongdoers.

the cap to dissuade some plaintiffs from suing at all, especially those in the more severely affected groups.[16] Indeed, "We're taking one out of 300 cases," said one attorney.[17]

- Cases involving medical malpractice in emergency rooms have been knocked out almost completely, making Texas ER's some of the most dangerous in the country. "'What Texans don't know is that their Legislature has mandated a very low standard of care — almost no care,' says Brant Mittler, a Duke University-educated cardiologist in San Antonio who added malpractice law to his resume in 2001.'"[18]
- A June 1, 2009, *New Yorker* magazine article by Dr. Atul Gawande, called "The Cost Conundrum; What a Texas town can teach us about health care," explored why the town of McAllen, Texas, "was the country's most expensive place for health care." The following exchange took place with a group of doctors and Dr. Gawande:

  > "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.

- As this article seems to confirm, 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)."[19] 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

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[16] "The Impact of the 2003 Texas Medical Malpractice Damages Cap on Physician Supply and Insurer Payouts: Separating Facts from Rhetoric," *Texas Advocate*, pp. 25-34, Fall 2008.

[17] Terri Langford, "Texas laws are vague, abandoned or unfunded," *Houston Chronicle*, July 30, 2009.

[18] "ER Patients Can't Find Attorneys, Blame Tort Reform," *Texas Tribune*, December 12-20, 2010

[19] "Physicians still fear malpractice lawsuits, despite tort reforms," *Health Affairs*, September 2010; Volume 29, Issue 9, http://content.healthaffairs.org/content/29/9.toc

overestimate the likelihood of experiencing them."

- **According to the Harvard School of Public Health, "portraits of a malpractice system that is stricken with frivolous litigation are overblown."**

  - In May, 2006, the Harvard School of Public Health published a study in the *New England Journal of Medicine* about the medical malpractice system. 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."[20] 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.
    - Eighty percent of claims involved injuries that caused significant or major disability or death.
    - "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."
    - "Disputing and paying for errors account for the lion's share of malpractice costs."
    - "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."

- **Removing the undue "fear" of litigation - even if you could - would not change the culture of secrecy at hospitals.**

  - Fear of litigation is not the reason hospitals and doctors do not report errors or communicate with their patients. David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law and Charles Silver of the University of Texas School of Law, who have studied this problem, write, "[e]xhaustive chronicles

[20] Press Release, Study Casts Doubt on Claims That the Medical Malpractice System Is Plagued By Frivolous Lawsuits, Harvard School of Public Health, May 10, 2006. http://www.hsph.harvard.edu/news/press-releases/2006-releases/press05102006.html; David M. Studdert, Michelle Mello, et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," New England Journal of Medicine, May 11, 2006.

of malpractice litigation's impact on physicians never once assert that physicians freely and candidly disclosed errors to patients once upon a time, but stopped doing so when fear of malpractice liability increased. Instead, the historical evidence indicates that there was never much *ex post* communication with patients, even when liability risk was low."[21]

- In his book on medical malpractice, Tom Baker, then Connecticut Mutual Professor of Law and Director of the Insurance Law Center at the University of Connecticut School of Law, confirmed, "to prove that lawsuits drive medical mistakes underground, you first have to prove that mistakes would be out in the open if there were no medical malpractice lawsuits. That is clearly not the case."[22]
- A May 11, 2006 article in the *New England Journal of Medicine* noted that only one quarter of doctors disclosed errors to their patients, but "the result was not that much different in New Zealand, a country that has had no-fault malpractice insurance" [i.e., no litigation against doctors] for decades. In other words, "There 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."[23]
- According to a recent study by Dr. Thomas Gallagher, a University of Washington internal-medicine physician and co-author of two studies published in the *Archives of Internal Medicine*, "Comparisons of how Canadian and U.S. doctors disclose mistakes point to a 'culture of medicine,' not lawyers, for their behavior."[24] 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… yet "doctors are just as reluctant to fess up to mistakes." Moreover, "doctors' thoughts on how likely they were to be sued didn't affect their decisions to disclose errors." The authors believe "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."[25]
- Another example is in Massachusetts, where nearly all hospitals fall under the state's charitable immunity laws that cap their liability at $20,000. Yet hospitals are still "vastly underreporting their mistakes to regulators and the public." According to *Boston Magazine,* "The biggest challenge is finding a way to break the culture of silence in hospital corridors that has long crippled efforts to cut medical errors, just as the blue wall of silence has stifled police investigations.[26]
- Hyman and Silver offer a number of explanations for physicians failure to report errors: a culture of perfectionism within the medical profession that shames, blames, and even humiliates doctors and nurses who make mistakes; fragmented delivery systems requiring the coordination of multiple independent providers; the prevalence of third-party payment systems and administered prices; overwork, stress, and

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[21] David A Hyman and Charles Silver, "The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?," 90 Cornell L. Rev. 914 (2005).
[22] Tom Baker, *The Medical Malpractice Myth* (2005) at 97.
[23] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.
[24] Carol M. Ostrom, "Lawsuit fears aren't reason for docs' silence, studies say," *Seattle Times*, August 17, 2006 , citing from Thomas Gallagher, M.D., et al, "Choosing your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients," *Archives of Internal Medicine*, Aug. 14, 2006.
[25] *Ibid*.
[26] Doug Most, "The Silent Treatment," *Boston Magazine*, Feb. 2003.

burnout; information overload; doctors' status as independent contractors and their desire for professional independence; the Health Insurance Portability and Accountability Act (HIPAA); a shortage of nurses; and underinvestment in technology that can reduce errors.[27] They write, "It is naive to think that error reporting and health care quality would improve automatically by removing the threat of liability."[28]

INSURER PROFITS

- **Medical malpractice insurers have been incredibly profitable in recent years.**
    - In the 2009 report *True Risk*, Americans for Insurance Reform 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.[29] Medical malpractice insurers admitted that they had "a very good" 2008.[30] This came "after posting record profits in 2007."[31] A.M. Best predicted that their "operating profits will continue through 2009."[32] And a quick look at the most recent data shows this to be true.
    - We reported in *True Risk* that in 2007 – the last year data was available - 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.[33] *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.) According to A.M. Best, the loss ratio for medical malpractice insurers has been declining for at least five years.[34] 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, 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

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[27] David A Hyman and Charles Silver, "The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?," 90 Cornell L. Rev. 897-99 (2005); Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007).
[28] *Ibid.*
[29] Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009; http://insurance-reform.org/pr/090722.html.
[30] "Solid Underwriting Undercut by MPLI's Investment Losses," *Best's Special Report*, A.M. Best, April 27, 2009.
[31] *Ibid.*
[32] *Ibid.*
[33] *Ibid.; Report on Profitability by Line by State in 2007*, National Association of Insurance Commissioners, 2008, p. 38.
[34] "Solid Underwriting Undercut by MPLI's Investment Losses," *Best's Special Report*, A.M. Best, April 27, 2009.

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.[35] 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.[36]

- Reserves are now dropping at a substantial rate, with a whopping 13.6% drop in the last two years examined by AIR.[37] Yet they have even further to go! According to a December 2010 ISO publication, which examined reserves at year-end 2009, reserves are still redundant (i.e., excessive) for medical malpractice policies: 15% to 35% for occurrence policies and by 41% to 61% for claims made policies. *This means rates still have much further to fall (see next bullet point)!*
- In Texas, an Austin-based medical malpractice insurer– American Physicians Service Group Inc. - agreed in September to be acquired by Alabama's ProAssurance Corp. for about $250 million in cash. The company earned $6.2 million on $20.7 million in revenue in the second quarter that ended June 30. … ProAssurance CEO W. Stancil Starnes said APS' strength in Texas made it an attractive acquisition candidate. ProAssurance currently writes about $10 million in premiums in Texas."[38]

MEDICAL MALPRACTICE PREMIUMS

- **Medical malpractice premiums, inflation-adjusted, are nearly the lowest they have been in over 30 years and they may go even lower.**

  - From the late 1980s through about 2001, doctors and hospitals nationwide experienced a relatively stable medical malpractice insurance market. Insurance was available and affordable. Rate increases were modest, often far below medical inflation. Meanwhile, profits for medical malpractice insurers soared, generated by high investment income. During this period, doctors benefited from an extended "soft market" period. That changed after 2001. After dropping interest rates and an economic downturn, compounded by years of cumulative price cuts during the prolonged soft market, insurers suddenly began raising premiums and canceling some coverage for doctors, or at least threatening to do so, in virtually every state in the country. This was an industry-wide insurance phenomenon, not just a medical malpractice phenomenon. It was not a state-specific phenomenon either. It was not even a country-specific phenomenon. It was even happening in countries like Australia and Canada that do not have jury trials in civil cases. This was a classic "hard market."

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[35] Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009; http://insurance-reform.org/pr/090722.html.

[36] Americans for Insurance Reform, Stable Losses/Unstable Rates 2007, http://www.insurance-reform.org/StableLosses2007.pdf.

[37] Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009; http://insurance-reform.org/pr/090722.html.

[38] Lori Hawkins, "Alabama health care policy writer says American Physicians Service Group will be a good fit for both companies," *Austin American-Statesman*, September 1, 2010.

- Texas' cap on non-economic damages was passed at the end of the last "hard market," when rate hikes were still skyrocketing around the country. Not surprising, after Prop. 12 passed, major insurers requested rate hikes as high as 35 percent for doctors and 65 percent for hospitals.[39] The insurance commissioner disallowed these. 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.[40]
- Like all hard markets, it did not last. In fact, the entire country has been in a "soft" insurance market for several years now, stabilizing rates everywhere in the country – not just Texas![41] 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.
- The insurance pure premium[42] or loss costs,[43] 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. The Insurance Services Office (ISO)[44] 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 data confirms that we are experiencing a very soft market. 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.[45]
- Premiums have dropped irrespective of whether "tort reforms" were enacted in any particular state, such as Texas.[46] 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.[47] Compare, for example,

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[39] *E.g.* Darrin Schlegel, "Some Malpractice Rates to Rise Despite Prop. 12," *Houston Chronicle*, Nov. 19, 2003; Darrin Schlegel, "Malpractice Insurer Fails in Bid for Rate Hike," *Houston Chronicle*, Nov. 21, 2003; (October 2003 rate filing from Texas Medical Liability Insurance Association (JUA) to Texas Department of Insurance).

[40] "Insurer Switching to Unregulated Product to Raise Premiums," *Assoc. Press*, April 10, 2004.

[41] See data from the Council of Insurance Agents & Brokers cited in Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009; http://insurance-reform.org/pr/090722.html. See also, Joanne Doroshow, "Here's Really Why Your Insurance Rates Go Up - and Then Don't," http://www.huffingtonpost.com/joanne-doroshow/heres-really-why-your-ins_b_775077.html

[42] "Pure premium" is a term used interchangeably with "loss costs." It is the part of the premium used to pay claims and the cost of adjusting and settling claims, including adjuster and legal expenses.

[43] "Loss cost" is the term for the portion of each premium dollar taken in, that insurance companies use to pay for claims and for the adjustment of claims. Insurers use other parts of the premium dollar to pay for: their profit, commissions, other acquisition expenses, general expenses and taxes. Loss costs include both paid and outstanding claims (reserves are included through an actuarial process known as "loss development") but also include trends into the future since rates based on ISO loss costs are for a future period. Thus, loss costs include ISO's adjustments to make sure that everything is included in the price, even such factors as future inflation.

[44] The ISO has the largest database of audited, unit transaction insurance data of any entity in the United States.

[45] Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009. http://insurance-reform.org/pr/090722.html.

[46] *Ibid.*

[47] *Ibid.*

Missouri and Iowa, two neighboring Midwest states. Missouri has had a cap since the mid-1980s, as well as other "tort reform" in medical malpractice cases. Iowa has never had a cap. In the last five years, 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.

- As mentioned above, rates are expected to drop even further! According to a December 2010 ISO publication, which examined reserves at year-end 2009, reserves are still redundant (i.e., excessive) for medical malpractice policies: 15% to 35% for occurrence policies and by 41% to 61% for claims made policies. *This means rates still have much further to fall.*

ACCESS TO CARE

- **There is no correlation between where physicians decide to practice, their choice of specialty, and liability laws.**
  - On August 29, 2003, the U.S. General Accountability Office released a study[48] ostensibly to find support for the AMA's 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" and "not substantiated," and that to the extent there are a few access problems, many other explanations can be established "unrelated to malpractice," that problems "did not widely affect access to health care," and/or "involved relatively few physicians." 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."
  - Other studies have also rejected the notion that there has been any legitimate access problem due to doctors' malpractice insurance problems. In August, 2004, the 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."[49]
  - Other state-specific studies draw the same conclusion. In April 2007, Michelle Mello of the Harvard School of Public Health 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

[48] *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, General Accounting Office, GAO-03-836, Released August 29, 2003, http://www.gao.gov/new.items/d03836.pdf
[49] http://www.dartmouth.edu/~kbaicker/BaickerChandraMedMal.pdf

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.... 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."[50]

- Similarly, the *Cincinnati Enquirer* 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."[51]
- Past studies have also shown there to be 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."[52] 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."[53]
- It is well-documented that lifestyle considerations are the most important factor for determining not only a doctor's choice of location, but also his or her choice of specialty - far more important than income and expenses. As reported in the *New York Times*, "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."[54] For example, compared to dermatology, which is becoming a more competitive specialty, "'The

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[50] "Malpractice Premium Spike In Pennsylvania Did Not Decrease Physician Supply; Contrary To Survey Responses, The Number Of Physicians In "High-Risk" Specialties In Pennsylvania Who Restricted Or Left Their Practices Did Not Increase During Malpractice "Crisis", *Health Affairs*, April 24, 2007; http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.3.w425.

[51] Tim Bonfield, "Region Gains Doctors Despite Malpractice Bills," *Cincinnati Enquirer*, October 11, 2004.

[52] Kinney, "Malpractice Reform in the 1990s, Past Disappointment, Future Success?" 20 *J. Health Pol. Pol'y & L.* 99, 120 (1996), *cited in* Marc Galanter, "Real World Torts," 55 *Maryland L. Rev.* 1093, 1152 (1996).

[53] Kinney & Gronfein, "Indiana's Malpractice System: No-Fault by Accident," 54 *Law & Contemp. Probs.* 169, 188 (1991), *cited in* Marc Galanter, "Real World Torts," 55 *Maryland L. Rev.* 1093, 1152-1153 (1996).

[54] Matt Richtel, "Young Doctors and Wish Lists: No Weekend Calls, No Beepers, *New York Times*, January 7, 2004.

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.'"

- Another key factor is age. 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 study 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."[55]
- Finally, we asked David Goodman, M.D., M.S., Professor of Pediatrics and Health Policy at Dartmouth Medical School, about his views on the subject. 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. His email to us 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."

- **Texas still suffers from the same rural doctor shortages as before caps were passed.**

  - Injured Texans relinquished their legal rights because the insurance and medical lobbies told them this was the only way to prevent a doctor shortage in Texas. Yet doctors' shortages still loom in Texas today. This is apparently due to "[C]aps and cuts in Medicare and Medicaid funding, which help pay for residencies. Those have forced many healthcare agencies to freeze or scale back residency programs." Specifically, with a ratio of 158 doctors per 100,000 residents, Texas ranks 42nd among the 50 states and District of Columbia, according to the Texas Medical Association. "We are at a shortage of physicians of all types in Texas, both primary care and specialty care," said Dr. Gary Floyd, JPS Health Network chief medical officer said. "We would love to see this addressed in our new healthcare reform. How do we train more physicians?"[56]
  - According to Texas Watch, nearly half of all Texas counties do not meet the national standard of having 114 doctors for every 3,500 people.[57]
  - In December 2009, the *Ft. Worth Star-Telegram* reported,[58]

    > The number of new doctors in family practice, the area most in demand, has increased by only about 200, about 16 percent, and more than 130 counties still did not have an obstetrician or gynecologist as of October, according to a *Star-*

[55] NYPIRG, Center for Medical Consumers and Public Citizen, *The Doctor* Is *In: New York's Increasing Number of Doctors*, October 2004 at 20, citing Grumbach, et al. Charges for Obstetric Liability Insurance and Discontinuation of Obstetric Practice in New York, *The Journal of Family Practice,* Vol. 44, No. 1 (Jan. 1997) at 61.
[56] "JPS official warns Texas legislators of doctor shortage," *Star-Telegram*, October 19, 2010.
[57] http://www.tafp.org/news/stories/attachments/090601releaseIIB2154.pdf
[58] Diana Hunter, "Tort law brought more doctors, but its effect on patients is unclear," *Fort Worth Star-Telegram*, December 20, 2009.

Telegram analysis of licensing data from the Texas Medical Board.

At the same time, the number of specialists in Texas has increased sharply, with 425 psychiatrists, more than 900 anesthesiologists and five hair transplant physicians among the more than 13,000 new doctors in Texas in the five years after the Legislature's approval of the liability caps, the analysis found.

More than half the new doctors settled in the state's largest urban areas, not in rural areas, where the shortage has been most apparent.

Healthcare costs, meanwhile, have continued to rise in Texas. Proponents of malpractice caps predicted that costs would drop along with lawsuits and malpractice insurance rates.

"Consumers are much worse off today," said Alex Winslow, executive director of Texas Watch, a consumer advocacy group in Austin. "Not only have they not seen the benefits they were promised in healthcare, but now they've lost the ability to hold someone accountable. I think that puts patients at greater risk."

"DEFENSIVE MEDICINE" AND HEALTH CARE COSTS

- In over 30 years, premiums and claims have never been greater than 1% of our nation's health care costs.[59] Despite this, the claim is often made that these figures do not included the costs of so-called "defensive medicine," or the ordering of tests or procedures to avoid litigation and not because they are "medically indicated and necessary for the health of the patient," as required by Medicare.[60]

- In October 2009, the Congressional Budget Office has presented a new analysis (in the form of a 7-page letter to Senator Hatch) on "the effects of proposals to limit costs related to medical malpractice ('tort reform')" finding that "tort reform could affect costs for health care." It based its new analysis on a small handful of studies, several of which are noted to contradict each other. One of them suggests that 50,000 more people could die in the next ten years (beyond the 98,000 that already die annually from medical errors[61]) should Congress further limit legal rights of patients.

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[59] See, Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009; http://insurance-reform.org/pr/090722.html

[60] 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." 42 U.S.C. § 1320c-5(a)(1). Also, "[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." 42 U.S.C. § 1395y(a)(1)(A). 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."

[61] *To Err Is Human, Building a Safer Health System*, Institute of Medicine, 1999.

- CBO finds that even if the country enacted the entire menu of extreme tort restrictions listed,[62] it can go no farther than to find an extremely small percentage of health care savings, "about 0.5% or $11 billion a year at the current level -- far lower than advocates have estimated"[63]
- CBO found no evidence of pervasive "defensive medicine."[64] It found tiny health care savings – "0.3 percent from slightly less utilization of health care services" -- if severe tort reform were passed nationally. According to the CBO, if there is any problem at all, it's with Medicare, specifically its emphasis on "fee-for-service" spending, whereas private managed care "limit[s] the use of services that have marginal or no benefit to patients (some of which might otherwise be provided as 'defensive medicine')." In other words, CBO virtually admits that to the extent "defensive medicine" exists at all, it can be controlled through simply managing care correctly as opposed to taking away patients' rights and possibly killing and injuring more people.
- CBO says federal government spending will decrease by $41 billion while revenue will increase $13 billion,[65] yet direct financial burdens on the government should these laws pass are not recognized by CBO.
    - 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, he or she may be forced to turn elsewhere for compensation, particularly Medicaid. None of these increased Medicaid costs are considered.
    - 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.

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[62] A $250,000 cap on non-economic damages, $500 cap or two times the amount of economic damages, repeal of the collateral source rule, one-year date of discovery statute of limitations (3 years for children), and repeal of joint and several liability.

[63] Alexander C. Hart, "Medical malpractice reform savings would be small, report says," *Los Angeles Times*, October 10, 2009; http://www.latimes.com/news/nationworld/nation/la-na-malpractice10-2009oct10,0,4877440.story

[64] This is consistent with other studies. When the GAO tried to find evidence of "defensive medicine," they found instead, "Some officials pointed out that factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures. *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, General Accounting Office, GAO-03-836, Released August 29, 2003. See also, Dr. Atul Gawande, "The Cost Conundrum; What a Texas town can teach us about health care," New Yorker, June 1, 2009 ("'Come on,' the general surgeon finally said. 'We all know these arguments [about defensive medicine] are bulls**t. There is overutilization here, pure and simple.' Doctors, he said, were racking up charges with extra tests, services, and procedures.")

[65] This number seems somewhat farfetched. It is based on the theory that savings, which are assumed, will find their way into the pockets of wage earners and, as such, become taxable. Moreover, it assumes these "savings" rise steadily each year, suggesting that the practice of medicine will so change based upon these tort restrictions that there will be a never ending increase in the savings, or that the cost to the government for health care will increase each year and, as such, the dollar figure of the "savings" will proportionately increase. In any event, if there is raw data to support this number, it is certainly not provided here.

- Any legitimate analysis of tort system costs must consider the countervailing cost benefits of the legal system due to its deterrence function - future injuries and deaths prevented, health care costs not expended, wages not lost. Even Tillinghast Watson, which annually issues bloated "tort cost" (based on insurance cost) figures each year, qualifies its numbers by noting it fails to factor in the benefits or cost-savings from the tort system.

- Studies of defensive medicine frequently use anonymous physician "surveys" to establish its widespread existence. These are usually conceived by organized medicine, whose purpose it is to give the impression of a scientifically conducted poll, yet they are not. In fact, in 2003, the General Accountability Office condemned the use of "defensive medicine" physician surveys, noting everything from low response rates (10 and 15 percent) to the general failure of surveys to indicate whether physicians engaged in "defensive behaviors on a daily basis or only rarely, or whether they practice them with every patient or only with certain types of patients."[66] 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." And, "some officials pointed out that factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures. For example, a Montana hospital association official said that revenue-enhancing motives can encourage the utilization of certain types of diagnostic tests, while officials from Minnesota and California medical associations identified managed care as a factor that can mitigate defensive practices." Moreover, "According to some research, managed care provides a financial incentive not to offer treatments that are unlikely to have medical benefit."
- In 1994, the congressional Office of Technology Assessment (OTA) found that less than 8 percent of all diagnostic procedures were likely to be caused primarily by liability concerns. OTA found that 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."[67]
- Much has been written about how the problem of "self-referral" contributes to overutilization. Not too long ago, the *Washington Post* obtained some 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 *Post* also cited consistent data from the GAO and MedPac. Jean M. Mitchell, a professor for public

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[66] *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, General Accounting Office, GAO-03-836, Released August 29, 2003, http://www.gao.gov/new.items/d03836.pdf

[67] Office of Technology Assessment (OTA) U.S. Congress, Office of Technology Assessment, Defensive Medicine and Medical Malpractice, OTA-H--602 (1994).

policy and a health economist at Georgetown University suggested, getting rid of profit-driven medicine like this "could reduce the nation's health care bill by as much as a quarter."[68]

- Many other factors contribute to overutilization. For example, an investigative team recently took a look at C-Section rates in California, which has had a $250,000 cap since 1975. It found, "[W]omen were at least 17 percent more likely to have a cesarean section at a for-profit hospital than at a nonprofit or public hospital from 2005 to 2007. A surgical birth can bring in twice the revenue of a vaginal delivery.... In addition, some hospitals appear to be performing more C-sections for nonmedical 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."[69]

- **The impact of Texas "tort reform" on health care costs.**

  - According to the consumer group Texas Watch, "Medicare spending has risen 16% faster than the national average since Texas restricted the legal rights of patients. Four of the nation's 15 most expensive health markets as measured by Medicare spending per enrollee are in Texas.[70]
  - According to Families USA and Texas Watch, family health insurance premiums for Texas families are up 92% - more than 4.5 times faster than income.[71] Texas has the nation's highest rate of uninsured with 24.5% of Texans without health insurance."[72]

IMPACT OF RESTRICTIONS ON THE RIGHTS OF INJURED PATIENTS AND TAXPAYERS

We are somewhat hampered in our presentation today because we are unclear about what specific limits on patients' legal rights are being contemplated. However we can say without hesitation that limiting the rights of injured patients would have terrible consequences for both patients and taxpayers. "Tort reform" is a cost-shifting device. "Tort reform" laws take money from the hands of injured patients and their families and put it into the pockets of insurance companies. Those left to pick up the tab may be taxpayers, who may have the responsibility to pay for the care of the most seriously hurt. In other words, these measure would most likely increase the deficit, while unfairly increasing the obstacles that sick and injured patients face in the already difficult process of seeking compensation and prevailing in court. They will also reduce the financial incentive of institutions, such as hospitals and HMOs, to operate safely, which will lead to more costly errors.

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[68] Shankar Vedantam, "Doctors Reap Benefits By Doing Own Tests," *Washington Post*, July 31, 2009 http://www.washingtonpost.com/wp-dyn/content/article/2009/07/30/AR2009073004285.html

[69] See, e.g., http://www.dailybreeze.com/news/ci_16105879?source=rss

[70] See analysis by Texas Watch, http://www.texaswatch.org/wordpress/wp-content/uploads/2010/10/MedicareSpeding-HealthCosts.pdf 3

[71] Texas-Style "Reform" Fails Patients; Costs Up, Access Down, Texas Watch.

[72] See http://pubdb3.census.gov/macro/032007/health/h06_000.htm

DETERRENCE

- **Weakening The Tort System Will Increase Errors, Injuries and Deaths**
    - In its October 9, 2009 letter to Senator Orin Hatch on medical malpractice issues, the CBO noted, "The system has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for their losses …" CBO wrote, "imposing limits on [the right to sue for damages] might be expected to have a negative impact on health outcomes," yet it brushed aside its significance, not because it is untrue, but because it says there are too few studies on the topic. However, of the three studies that address the issue of mortality, CBO notes that one study finds such tort restrictions would lead to a .2 percent increase in the nation's overall death rate.[73] If true, that would be an additional 4,853 Americans killed every year by medical malpractice, or 48,250 Americans over the 10-year period CBO examines.[74]
    - 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.[75]) The costs of errors, which the Institute of Medicine put between "$17 billion and $29 billion, of which health care costs represent over one-half," would clearly increase.[76] Consider, for example, that the average length of stay per hospitalization is around 4.4 days[77] and the average cost in the hospital is approximately $2,000 per day per injury.[78] Consider those costs in addition to physician utilization inherent in caring for these new patients.
    - David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law, and Charles Silver of the University of Texas at Austin School of Law, have researched and written extensively about medical malpractice.[79] They confirm, "The field of surgical anesthesia, where anesthesiologists adopted practice guidelines to reduce deaths, injuries, claims and lawsuits, is a strong case in point. … [T]wo major factors forced their hand: malpractice claims and negative publicity.… Anesthesiology [malpractice] premiums were ... among the very highest—in many areas, two to three times the average cost for all physicians. By the early 1980s, anesthesiologists recognized that something drastic had to be done if they were going to be able to continue to be insured.… Anesthesiologists worked hard to protect patients *because* of malpractice exposure, not in spite of it."[80] "As Hyman and Silver explain, the reason why tort liability promotes patient safety is obvious. As the title of

[73] CBO says, "[t]here is less evidence about the effects of tort reform on people's health, however, than about the effects on health care spending – because many studies of malpractice costs do not examine health outcomes."
[74] Based on 2,426,264 deaths according to the Center for Disease Control and Prevention. http://www.cdc.gov/nchs/FASTATS/deaths.htm
[75] Study of California hospitals cited in Tom Baker, *The Medical Malpractice Myth*, University of Chicago Press, 2005.
[76] *To Err Is Human, Building a Safer Health System*, Institute of Medicine, 1999.
[77] http://www.cdc.gov/nchs/data/injury/InjuryChartbook/79-01_UtilPayment.pdf
[78] http://www.rtihs.org
[79] David A Hyman and Charles Silver, "The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?," 90 Cornell L. Rev. 893, 917 (2005).
[80] *Ibid* at 920, 921.

their most recent article says, 'it's the incentives, stupid': Providers are rational. When injuring patients becomes more expensive than not injuring them, providers will stop injuring patients..... In short, the notion that errors would decline if tort liability diminished is ridiculous."[81]

- 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.[82] As a result of such lawsuits, the lives of countless other patients have been saved.
- "The authors of the Harvard [Medical Practice Study] study acknowledged, as well: '[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.'"[83]
- The *New England Journal of Medicine* published a 2006 article confirming this point: that litigation against hospitals improves the quality of care for patients, and that "more liability suits against hospitals may be necessary to motivate hospital boards to take patient safety more seriously."[84]
- No one said this better than Dr. Wayne Cohen, then-medical director of the Bronx Municipal Hospital, who said, "The city was spending so much money defending obstetrics suits, they just made a decision that it would be cheaper to hire people who knew what they were doing."[85]

SPECIFIC PROPOSALS

- **Caps on Non-Economic Damages**

Non-economic damages are sometimes dismissed as unimportant or frivolous injuries. It is first important to understand what they are.

The joy of life - what makes it really worth living - is not the earning of money to pay to others for life's necessities. When a person is seriously injured, the greatest loss is the loss of the enjoyment of life, the pleasure, the satisfaction or the utility that human beings derive from life, separate and apart from earnings. These are non-economic injuries.

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[81] Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 47, citing David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 Vand. L. Rev. 1085, 1131 (2006).

[82] Meghan Mulligan & Emily Gottlieb, *Lifesavers: CJ&D's Guide to Lawsuits that Protect Us All*, Center for Justice & Democracy (2002), Hospital and Medical Procedures, A-36 *et seq.*; B-12 *et seq.*

[83] Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 47, citing Paul C. Weiler, Joseph P. Newhouse, & Howard H. Hiatt, A Measure Of Malpractice: Medical Injury, Malpractice Litigation, And Patient Compensation 133 (1993).

[84] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.

[85] Dean Baquet and Jane Fritsch, "New York's Public Hospitals Fail, and Babies Are the Victims," *New York Times*, March 5, 1995.

What is truly valuable to us as human beings is our ability to live life on a daily basis free of any debilitating physical or emotional problems that diminish our capacity to enjoy life and compromise our sense of self-worth, dignity, and integrity. The pleasure of living lies in our ability to participate fully in the give and take of marriage, family and career. It lies in our experience of the ordinary day: waking up without pain; drinking a cup of coffee without someone's help; dressing a child in mismatched clothes that she insists on wearing, rather than have that child dress you; walking to the bus stop or subway in the brisk air, rather than being wheeled to a lift van; accomplishing a job well done at work, rather than being limited to a make-work project for the disabled; deciding what to make for dinner and preparing it; these and thousands of everyday things are what we live for.

In addition to physical pain and suffering, the seriously injured victim suffers great mental anguish, anxiety and often shame at being transposed from an able-bodied working person respected for his or her accomplishments and contributions to others to an individual who is dependent on others. A seriously injured person is compromised in his or her ability to make decisions and realize them, to take independent action, and to reciprocate when someone helps them. A seriously injured person is also deprived of the pleasure of engaging as equals with other people, including family members, or participating in athletic activities, social and civic events, hobbies, volunteer activities and other interpersonal interactions.

These are sufferings which seriously injured people encounter each time they attempt to perform any of the myriad tasks of daily life the rest of us take for granted. This is the loss that the law describes as "non-economic," and which goes to the very essence of our quality of life.

Caps on non-economic damages do nothing but stop the most severely injured patients from getting adequate compensation.[86] They apply to all patients no matter how egregious the misconduct or devastating the injury. Clearly, juries are better able to determine compensation in individual cases than politicians in Washington, D.C.

They also have a devastating impact on Medicare patients and will add to the deficit, not decrease it. Noneconomic damages caps disproportionately hurt senior citizens, forcing Medicare to pay for their care instead of the culpable hospital's insurance company. That is because caps on non-economic damages make their cases economically impossible for attorneys to bring. The same goes for any injured person with low wages, such as women who work inside the home, children and the poor, who are more likely to receive a greater percentage of their compensation in the form of non-economic damages. In fact, this has already happened in states with non-economic damages caps, like California. Insurance defence attorney Robert Baker, who defended malpractice suits for more than 20 years, told Congress several years ago, "As a result of the caps on damages, most of the exceedingly competent plaintiff's lawyers in

[86] A survey by the RAND Corporation found that the "most significant impact" of California's three decades-old $250,000 cap "falls on patients and families who are severely injured or killed as a result of medical negligence or mistakes." Source: "RAND Study: California Patients Killed or Maimed by Malpractice Lose Most Under Damage Caps," Consumer Watchdog, July 13, 2004.

California simply will not handle a malpractice case … There are entire categories of cases that have been eliminated since malpractice reform was implemented in California."[87]

- **Modifying the "collateral source" rule to allow outside sources of income collected as a result of an injury (for example workers' compensation benefits or insurance benefits) to be considered in deciding awards.**

The collateral source rule prevents a wrongdoer, such as a negligent hospital, from reducing its financial responsibility for the injuries it causes by the amount an injured party receives (or could later receive) from outside sources. Payments from outside sources are those unrelated to the wrongdoer, like health or disability insurance, for which the injured party has already paid premiums or taxes. The collateral source rule is one of fairness and reason. The rule's premise is that the wrongdoer's liability and obligation to compensate should be measured by the harm done and the extent of the injuries inflicted. In this way, the rule helps promote deterrence.

In fact, representatives from the conservative American Enterprise Institute found that modifying the collateral source rule could endanger infant safety. They wrote:

> [C]ollateral source reform leads to a statistically significant increase in infant mortality.... For whites, the increase is estimated to be between 10.3 and 14.6 additional deaths per 100,000 births. This represents an increase of about 3 percent. For blacks, the collateral source reversal leads to between 47.6 and 72.6 additional deaths per 100,000 births, a percentage increase between 5 and 8 percent. These results suggest that the level of care provided decreases with the passage of collateral source reform....The relationships we estimate between reform measures and infant mortality rates appear to be causal.... In summary, these results show that collateral source reform leads to increased infant mortality."[88]

- **Imposing a statute of limitatious - perhaps one to three years - on medical malpractice lawsuits.**

This idea lacks logic from a deficit reduction angle since its only impact would be to cut off meritorious claims, especially those involving diseases with longer incubation periods. If a patient is harmed as a result of the medical negligence but unable to sue due to an unreasonably unfair statute of limitations period, he or she (or a child's family) would be forced to turn elsewhere for compensation, such as Medicaid. None of these increased costs are considered. In other words, unreasonably reducing a state statute of limitations would cause deficit increases, not decreases.

- **Modifying joint-and-several liability.**

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[87] See, http://www.multinationalmonitor.org/mm2003/032003/court.html

[88] Jonathan Klick & Thomas Stratmann, "Does Medical Malpractice Reform Help States Retain Physicians and Does It Matter?" (March 8, 2004), presented at American Enterprise Institute forum, "Is Medical Malpractice Reform Good for Your Health?," Sept. 24, 2003, available at http://www.aei.org/events/eventID.614/event_detail.asp.

According to CBO, this change could *increase* costs, not lower costs. Specifically, CBO said that modifying joint and several liability "may increase the volume and intensity of physician services." In other words, this change could cause a deficit increase, not decrease.

We also note that this proposal is unfair to injured patients. The doctrine of joint and several liability has been a part of the common law for centuries. It is a rule that applies to allocating damages when more than one defendant is found *fully responsible* for causing an entire injury. If one of them is insolvent or cannot pay compensation, the other defendants must pick up the tab so the innocent victim is fully compensated. Courts have *always* held that it applies only to injuries for which the defendant is fully responsible. That means that their negligent or reckless behavior must be an "actual and proximate" cause of the entire injury, a high standard.[89] Having said that, joint and several liability limits have already been enacted in over 40 states, so the proposal is also superfluous.[90]

- **"Health courts" for medical malpractice lawsuits.**

No one believes health courts would save money, especially if health court proponents are taken at their word. In fact, they would significantly increase costs. For example, in their book *Medical Injustice: The Case Against Health Courts* (2007), Case Western Reserve professors Maxwell J. Mehlman and Dale A. Nance, noted, "The Republican Policy Committee states, for example: 'The health court proposal is not about reducing costs overall (since many more people may be compensated at smaller amounts).'"[91] These authors made the following additional observations:

> Health courts "would entail some huge potential increases in total system costs.... If we take health care proponents at their word, their goal is to bring ... currently non-claiming people into the process." This, however "would multiply the number of claims involving negligence by a factor between 33 and 50."[92]
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> "[C]laims involving error account for at least 84 percent of total system costs ... so that, even if we assume that only claims involving error are brought into the system, the system costs should increase by a factor of at least 28, all other things (like system efficiency) being equal."[93]
>
> "[E]ven if we assume that the average per patient damages under a new system embracing all potential claimants (including those who claim under the existing system) would be only 30 percent of the average damages for claims now paid, that still leaves

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[89] *See, e.g.*, Richard Wright, "The Logic and Fairness of Joint and Several Liability," 23 *Memphis State Law Review* 45 (1992).
[90] See, e.g., Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, Appendix C, July 2009. http://insurance-reform.org/pr/090722.html.
[91] Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 74.
[92] *Id.* at 72.
[93] *Ibid.*

> total direct system costs multiplied by a factor of about 8.5, again as a low end estimate."[94]
>
> Health courts involve the creation of a new judicial or administrative bureaucracy. Costs "would certainly be substantial, vastly more than the public (taxpayer borne) judicial costs currently associated with the adjudication of malpractice claims."[95]

In addition to the significant cost issues, there are many other problems with health courts. Health courts force patients into an alternative system without juries, without any accountability mechanisms, without procedural safeguards, and without any meaningful appeals process. These hardships, coupled with the burden of having to prove fault or "causation," render the injured patient virtually powerless and at the mercy of the insurance and medical industries. Even patients with catastrophic injuries, including the families of brain-damaged babies, would have to fight a "causation" battle to obtain compensation for a potential lifetime of care. Decision-makers would be heavily weighted toward health industry or business representatives, who even might have conflicting financial interests in rejecting or reducing compensation. Some proposals suggests that compensation for injuries would be determined by a benefits "schedule" (so much for a lost leg, so much for an eye) developed by the medical establishment or political appointees instead of decided on a case-by-case basis by a jury.[96]

There are substantial constitutional problems with state and/or federal health court proposals, as well.[97]

- **Allowing "safe haven" rules for providers who follow best practices of care.**

Patient safety can benefit from clinical practice guidelines when triggered by the desire to reduce unwarranted variation in practice and provide patients with benchmark quality care rooted in science. In fact, both sides in malpractice litigation currently make limited use of clinical practice guidelines in settlement negotiations, or even to help lawyers decide whether or not to file suits. However, providing immunity for those who follow practice guidelines raises serious fairness and patient safety concerns. Moreover, the medical communities in states that have tried it have rejected this idea. In other words, the medical profession itself has not accepted clinical practice guidelines as appropriate legal standards, even for exculpatory purposes. And the few states that have tried – and subsequently rejected – this proposal saw no impact on claims costs or premiums.

First, we note that clinical practice guidelines should never be the legal basis for determining whether or not patient harm was the result of negligence. There is already a general recognition that conflict of interest and specialty bias are ongoing problems in the development of clinical

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[94] *Ibid.*

[95] *Id.* at 73.

[96] See, Testimony of Neil Vidmar, Russell M. Robinson, II Professor of Law, Duke Law School before The Senate Committee on Health, Education, Labor and Pensions, "Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006.

[97] See, Amy Widman and Francine A. Hochberg, "Federal Administrative Health Courts Are Unconstitutional: A Reply to Elliott, Narayan, and Nasmith," 33(4) Journal of Health Politics, Policy and Law 799 (2008); Amy Widman, "Why Health Courts are Unconstitutional," 27 Pace L. Rev. 55 (Fall 2006).

practice guidelines. If medical and specialty societies are allowed to participate in writing guidelines they know will be exculpatory for their members, conflicts of interest and bias will escalate. For example, specialty societies, like the American College of Obstetricians and Gynecologists (ACOG), have been aggressive leaders in the medical lobbies' push for liability limits in the last few years and remain committed to that goal. It would be fundamentally unjust for patients to have their cases judged by liability standards chosen by ACOG for the purpose of exculpating fellow obstetricians.

But the reality is that no matter who writes them, it is impossible to develop single authoritative guidelines for every medical condition, let alone to trust any entity to suddenly become the sole arbiter of acceptable medical practice.[98] It is estimated that more than 1,400 sets of clinical practice guidelines exist today. While some standards, such as those in anesthesia, are clear and easily complied with, others, such as in obstetrical cases, are complicated and can be contradictory. Moreover, as they are written for "average patients" and cannot encompass the huge variation in how patients present, there may be good reason to vary from a guideline's recommendation for a patient.

That is why to date, only a few states have attempted to develop and use certain guidelines as legal standards. These limited state experiments, which began and ended in the 1990s, provide no support for adoption of guidelines as national policy.

For example, in the 1990s, Maine established a program that allowed doctors in four specialties--anesthesiology, emergency medicine, obstetrics and gynecology, and radiology--to participate in a program allowing use of guidelines as exculpatory evidence in lawsuits.[99] Other specialties were encouraged to take advantage of this program but did not. The program expired, and the Maine Bureau of Insurance concluded, "The medical demonstration project had no measurable effect on medical professional liability claims, claims settlement costs, or malpractice premiums."

In 1996, Florida also began a demonstration project for cesarean deliveries, but reportedly "garnered relatively little support among physicians--only 20% of physicians eligible to participate chose to do so and the project ended in 1998.... Three other states (Kentucky, Maryland, and Minnesota) adopted test projects in the 1990s, though none of the projects is fully operational today (the Maryland and Minnesota projects have fully expired)."

Finally, allowing use of guidelines only by a physician or facility to defend itself against a medical malpractice claim and not by an injured patient to show negligence lacks any purpose except to exempt medical providers at injured patients' expense.

ONE THING CONGRESS CAN DO: REPEAL THE ANTI-TRUST EXEMPTION

For medical malpractice insurers, high-pressure tactics have paid off and will pay off again unless Congress takes responsible, remedial steps to reign in the power and control the abuses of

[98] See, http://www.ahrq.gov/clinic/jhppl/rosoff1.htm
[99] See, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2793844/.

insurance companies. Otherwise, we will never be able to deal systematically with the tactics of this industry, which consistently looks for scapegoats to cover up its own instability and mismanagement.

One thing Congress could do is repeal the insurance industry's federal anti-trust exemption. Since 1944, the McCarran-Ferguson Act has allowed insurance companies to fix prices. A law repealing the federal anti-trust exemption would ensure that all domestic and foreign insurers and reinsurers that do business in the United States are subject to federal anti-trust prohibitions applicable to other industries. Such legislation would prohibit the insurance industry from acting in concert to raise prices and would prohibit tying arrangements, market allocation among competitors and monopolization.

If the McCarran-Ferguson Act were repealed, the industry-owned and controlled, for-profit Insurance Services Office, Inc. (ISO) and other rating bureaus could still jointly collect, compile and disseminate past data relating to premiums and claims. However, price-fixing agreements would be illegal. Moreover, ISO would be forced to disclose to insurance buyers the documents it prepares for insurance sellers, listing both current prices major insurers charge for auto and homeowner insurance and the ISO advisory rates.

PATIENT SAFETY IS THE ANSWER, INCLUDING FOR HIGH-COST OBSTETRICAL INJURIES

I served on a New York State medical malpractice task force in 2007 and 2008, which among other things, discussed ways to improve patient safety as the best way to reduce injuries, claims, lawsuits and costs to the system. The presentation by Dr. Ronald Marcus Director of Clinical Operations, Department of Ob/Gyn at Beth Israel Deaconess Medical Center and Assistant Professor of the Harvard Medical School, was instructive. His presentation not only acknowledged the extent of birth injuries caused by OB error, but discussed the reasons for this and proven methods to correct the situation.

Dr. Marcus specifically discussed the concept of team training or crew resource management that was developed by NASA to deal with pilot error. Dr. Marcus found that with crisis management training in OB emergencies, patient outcomes dramatically improved, with a 50 percent decrease in low Apgars, neonatal encephalopathy. With crew resource management in place, he has seen a 23 percent decrease in frequency and 13 percent decrease in severity of adverse events, and a 50 percent decrease in OB malpractice cases. It should be noted that if medical errors were not the cause of a certain birth-related injuries, as some doctors insist, clearly these kinds of statistics would not exist.[100]

[100] See also, Testimony of Neil Vidmar, Russell M. Robinson, II Professor of Law, Duke Law School before The Senate Committee on Health, Education, Labor and Pensions, "Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006 (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.").

CONCLUSION

History is clear on this matter: taking away the rights of the most seriously injured in our society has been and continues to be a failed public policy. Laws and proposals that increase the obstacles sick and injured patients face in the already difficult process of prevailing in court are certainly the wrong way to respond to the important economic problems that face this country. Tort restrictions will add to the deficit and will reduce the financial incentive of institutions like hospitals and HMOs to operate safely, when our objectives should be deterring unsafe and substandard medical practices while safeguarding patients' rights. Indeed, our goal must be to reduce medical negligence. Moreover, effective insurance reforms, like repealing the McCarran-Ferguson Act, are the only way to stop the insurance industry from abusing its enormous economic influence, which it uses to promote a legislative agenda that bilks taxpayers and severely hurts the American public.

Mr. SMITH. Thank you, Ms. Doroshow.
Dr. Weinstein?

TESTIMONY OF STUART L. WEINSTEIN, M.D., HEALTH COALITION ON LIABILITY AND ACCESS

Dr. WEINSTEIN. Thank you, Chairman Smith and Ranking Member Conyers, for holding this important hearing to consider fixing our country's broken liability system.

I am Stuart Weinstein. I am the Ponseti Chair and professor of orthopedic surgery and professor of pediatrics at the University of Iowa. I have been a practicing pediatric orthopedic surgeon for more than 35 years. I am the past president of the American Academy of Orthopedic Surgeons and the American Orthopedic Association.

I would like to begin today by asking each of you to put yourself in someone else's shoes. Imagine you are a young, pregnant mother living in rural America with no OB/GYN practitioner or your local hospital has closed its door to obstetrics. Or imagine you are a young doctor, saddled with debt, trying to pick a specialty. Despite the great need for OB/GYNs, neurosurgeons, trauma physicians, and general surgeons, you choose a safer specialty because of risk of lawsuit. And, finally, imagine you are an orthopedic surgeon, in practice for three decades, but you are facing similar high costs for liability insurance and the threat of potential litigation. To reduce your liability, you decide to avoid high-risk cases like trauma cases, or maybe you decide to retire altogether.

Dilemmas like these play out across America every day, as medical lawsuit abuse undermines both our health-care system and the doctor-patient relationship. Moreover, medical lawsuit abuse is driving up health-care costs at a time when we are still reeling from one of the worst recessions in modern times.

I am here today to ask you to create a climate for patient-centered care by reforming the medical liability system that continues to put everyone's health care at risk. The current system is clearly broken, and there is widespread agreement amongst lawmakers, health-care policy experts, opinion leaders, and the public that reform is needed.

Today, more than 90 percent of OB/GYNs have been sued at least once. One-third of orthopedic surgeons, trauma surgeons, emergency doctors, and plastic surgeons are sued in any given year, and neurosurgeons once every 2 years, on the average. And, as you know, most claims are without merit. This toxic litigation environment is fundamentally changing the doctor-patient relationship. It is driving doctors to get out of medicine or to practice defensive medicine.

Defensive medicine is the antithesis of health-care reform because it increases health-care costs. And it has the potential to lessen access to care and quality of care in two ways.

First, doctors practice assurance behavior, which includes ordering tests, particularly imaging studies, performing diagnostic procedures or referring patients in order to provide an extra layer of protection against abusive lawsuits. A recent Gallup survey found that the fear of lawsuits was the driver behind 21 percent of all tests and treatments ordered by doctors, which equates to 26 percent of all health-care dollars, a staggering $650 billion.

Defensive medicine also includes avoidance behaviors, where doctors eliminate high-risk procedures like head injury, trauma sur-

gery, vaginal deliveries, or procedures prone to complications, and they avoid patients with complex problems or patients who seem litigious.

In 2008, almost half of America's counties had no practicing obstetricians. This shouldn't be happening in America. And, unfortunately, the PPACA was not comprehensive reform, as it didn't address this critical issue.

There are remedies to fix this broken system, but it is imperative that we act now before defensive medicine practices, and costs associated with it, becomes the standard of care, before health-care costs go higher and unemployment along with it, before doctor shortages change the very nature of our health-care system.

Successful reform efforts in States, especially California and Texas, have given us a blueprint for Federal medical liability reform legislation. HCLA has outlined several legislative proposals that preserve State laws already working effectively to make the medical liability system fair for both patients and health-care providers, but also broaden coverage across the Nation.

I would like to close by telling you about a Maryland gynecologist, Dr. Carol Ritter, who stopped delivering babies in 2004 when her liability premiums hit $120,000 a year. She couldn't deliver enough babies to pay the trial bar's tab. Today, Dr. Ritter maintains a gynecology practice and still delivers babies, but she does it in Haiti and Honduras and Bosnia, where she joins relief efforts helping women in these impoverished places get obstetrical care, including delivering babies. She says she does it for the sheer joy of what she does best, but she can't do it in Maryland.

I would say to you today that something is very wrong when a caring, committed physician like Dr. Ritter can't bring an American baby into this world for fear of frivolous lawsuits. Ladies and gentlemen, you have the ability and, I think, the responsibility to help right that wrong.

Thank you very much.

[The prepared statement of Dr. Weinstein follows:]

PREPARED STATEMENT OF STUART L. WEINSTEIN

Statement of

Stuart L. Weinstein, M.D.

on the subject of

Medical Liability Reform:

Cutting Costs, Spurring Investment, Creating Jobs

before the

Committee on the Judiciary

U.S. House of Representatives

January 20, 2011

Health Coalition on Liability and Access P.O. Box 70096 Washington, DC 20013-8096 www.hcla.org

INTRODUCTION

Thank you, Chairman Smith and Ranking Member Conyers for holding this important hearing to consider the unfinished business of fixing our country's broken medical liability system. I am grateful for the opportunity to appear before this honorable committee, which has a long and proud history of righting many of the nation's wrongs. Ending the inequities and inefficiencies in our medical liability system is yet one more challenge that I am hopeful this committee will meet.

If I could, I'd like to take just a moment to present my credentials. I am currently the Ponseti Chair and Professor of Orthopaedic Surgery and Professor of Pediatrics at the University of Iowa. I have been a practicing physician for more than 35 years specializing in pediatric orthopaedic surgery. I am the past president of the American Academy of Orthopaedic Surgeons, the American Orthopaedic Association, the Pediatric Orthopaedic Society of North America, the American Board of Orthopaedic Surgery and former chairman of Doctors for Medical Liability Reform.

Thank you again for the opportunity to appear here today. I'd like to begin by asking each of you to put yourself in someone else's shoes. Imagine that you are a young mother-to-be living in a rural area of our nation worried about your first baby. Will it be healthy? Will the delivery go smoothly? Will I get to the hospital in time? For most mothers that last question is usually the easiest to answer. But not for all mothers. Imagine what could happen with no OB-GYN practitioner in your area or if your local health care facility had closed its doors to obstetrics. Instead of a quick trip to a hospital just a few minutes or miles away when labor begins, you are forced to race perhaps a hundred miles to deliver the most precious gift you will ever receive: your child.

Now, I'd like you to imagine yourself a young doctor facing, what should be an exciting decision, that of choosing a medical specialty. You know you will be leaving medical school with as much $100,000 or more in debt. You know there is great need for OB-GYNs, neurosurgeons, trauma physicians and general surgeons. But you also know that your liability insurance rates will be dramatically higher in these specialties, and that your chances of being the target of a personal injury lawsuit will be much greater. You'd like to go into trauma medicine and return to your hometown hospital. But, you decide to choose a "safer" specialty and because your state hasn't passed liability reform, you move to another state with a friendlier litigation environment.

Finally, a last scenario. This time you are a 50-year-old orthopaedic surgeon. You've been practicing medicine for three decades but you are facing a similar dilemma as that young doctor fresh out of medical school -- the high cost of liability insurance and the threat of potential litigation. To reduce your liability, you decide to avoid high-risk cases, like trauma victims or maybe you decide to retire altogether.

Three different stories -- all with the same ending. Patients in need likely losing access to quality and affordable health care. Patients like the high-risk woman who can't find a local doctor for her prenatal care. Or a senior side-lined with painful arthritis who must

wait perhaps months for a knee replacement because the only orthopaedic surgeon in town has a waiting list a mile long. Or the accident victim who might have been saved if the nearby trauma center hadn't closed for lack of ER physicians to staff it.

Sadly, situations like these are real in areas across the country. In 2002, Las Vegas became the only city of its size in the country without a level-one trauma center when dozens of doctors serving the University Medical Center's trauma center resigned amidst a growing liability crisis.[1] The trauma center closed its doors leaving the people of southern Nevada without the kind of cutting edge care that a world-class trauma center can provide. Patients had to go as far away as Los Angeles to get life saving care. Two years later, voters passed a ballot initiative locking in a package of medical liability reforms that finally ended the crisis.

Less than two weeks ago, this very institution was reminded of the value of a level-one trauma center. When dealing with brain injuries, like so many other traumatic injuries, minutes matter. Without prompt access to a premier trauma department, the positive outcome we see today might have been very different.

The impact of the nation's broken medical liability system extends from physicians and health care providers to patients and all Americans.

Medical lawsuit abuse is also driving up health care costs at a time when the nation is still reeling from one of the worst recessions in modern times. And when health care costs go up, employment will likely go down.

As doctors fall back on defensive medicine to protect themselves and their practices from abusive lawsuits, the overall costs of health care rise for patients and employers, punishing business, especially small business, and eroding our competitiveness in a global economy. Because doctors face large fixed costs associated with paying steep medical liability premiums, they have reduced resources that could be spent on hiring nurses and other support staff to help deliver quality care. Finally, fewer resources mean less money to invest in medical technology and equipment, which harms economic growth in key industries.

Clearly, the medical liability system exacerbates the already difficult challenge of providing improved access to health care while ensuring the quality of care for more than 300 million Americans and, moreover, is a drag on our weak economy.

Time is running out on our healthcare system. So, I am here today to ask you to take action. I ask you <u>to create a climate for patient centered care by reforming the medical liability system that continues to put everyone's health care at risk.</u>

Despite some successful state initiatives to rein in medical liability costs, medical lawsuit abuse remains a national problem. Congressional leaders and the President acknowledged as much by placing demonstration projects in the Patient Protection and

Affordable Care Act, but those projects will not be sufficient to remedy this problem in any serious way.

CONSENSUS ON THE NEED FOR MEDICAL LIABILITY REFORM IS GROWING

The current system is clearly broken, and there is widespread agreement among lawmakers, health care policy experts, opinion leaders and the public that reform is needed and needed now. In a recent *New York Times* editorial (10/20/10), former OMB Director Peter Orszag wrote of the health care reform bill, "...it does almost nothing to reform medical malpractice laws. Lawmakers missed an opportunity to shield from malpractice liability any doctors who followed evidence-based guidelines in treating their patients."[2] We agree.

Senator Orrin Hatch said in an ABC television interview with Senator John Kerry, "We've got to find some way of getting rid of frivolous cases, and most of them are." Kerry responded, "And that's doable, most definitely."[3]

In September 2009, HHS Secretary Kathleen Sebelius admitted in a news conference, "...we've got a situation where there are frivolous lawsuits being filed against practicing physicians, discouraging some from practicing in certain areas."[4] We agree.

Even more recently, both the Bipartisan Policy Center's Debt Reduction Task Force and the National Commission on Fiscal Responsibility and Reform recognized the need for comprehensive medical liability reform to help address the nation's deficit.

The President himself has weighed in on the issue writing in the *New England Journal of Medicine* in Oct. of 2008, that he "would be open to additional measures to curb malpractice suits and reduce the cost of malpractice insurance. We must make the practice of medicine rewarding again." In an earlier NEJM article, he said, "the current tort system does not promote open communications to improve patient safety. On the contrary, it jeopardizes patient safety by creating an intimidating liability environment."[5]

We agree with that, too, and wish the President's sentiment had been reflected in the health care reform bill. Apparently, the American people agree as well and understand the threat that abusive lawsuits pose to the quality and accessibility of their health care. In a poll done by the Health Coalition on Liability and Access (HCLA) in October 2009, 69 percent of Americans said they wanted medical liability reform included in health care reform legislation. Seventy-two percent said that their access to quality medical care is at risk because lawsuit abuse forces good doctors out of the practice of medicine. A Rasmussen poll done at the same time found that 57 percent of people favored limiting jury awards.[6]

<u>We believe that a consensus has emerged: health care reform without medical liability reform is not reform. Congress must finish the job.</u>

We understand that meeting the challenges of America's complex healthcare system is not an easy task. Nor is fixing a broken medical liability system which drives up health care costs and drives good doctors out of the system, putting patients at risk.

We're not advocating doing away with medical liability. Reasonable medical liability remedies that protect the rights and interests of patients who have suffered injury through error and especially negligence must be an important part of our health care system. But the key word is "reasonable" and that is *not* how I would define our current litigation environment.

Today, I would like to talk with you about how medical lawsuit abuse is affecting providers and patients, and, at the end of the day, putting American health care at risk.

THE STATE OF MEDICAL LIABILITY IN AMERICA

Let me begin with a brief situational analysis -- the state of medical liability in America. There is no question that medical lawsuit abuse is undermining both our healthcare system and the doctor-patient relationship. Medical liability has devolved from a system designed to protect patient rights and improve the quality of health care, to a system designed to reward personal injury lawyers looking for big payoffs in the guise of seeking justice.

The trial bars' own track record speaks to the dubious legitimacy of the majority of their litigation. In 2009, 64 percent of all medical liability cases were withdrawn, dropped or dismissed as being without merit, according to the Physician Insurers' Association of America. Less than one percent (0.8 percent) resulted in a verdict favoring the plaintiff, yet these cases continue to be filed as personal injury lawyers play roulette with America's doctors, hospitals and patients.[7]

But a poor win/loss record hasn't stopped personal injury lawyers. Instead, they have become even more aggressive in their tactics. In 2009, the Institute for Legal Reform released a report showing that television ads for medical liability lawsuits increased by 1,400 percent in four years as spending reached an all-time high of $62 million -- up from just $3.8 million in 2004.[8]

Richard A. Epstein, director of the law and economics program at the University of Chicago Law School put it this way in an *American Medical News* story that compared U.S. litigation costs with those of other countries. He said, "Nobody is as hospitable to potential liability as we are in this country. The unmistakable drift is we do much more liability than anybody else, and the evidence on improved care is vanishingly thin."[9]

We know that our medical liability costs are at least twice those in other developed countries[10] and make up 10 percent of all tort cases. That's the macro perspective, but what about the physicians, hospitals or other health care providers on the wrong end of a lawsuit? They can expect to pay an average of $26,000 to defend a case that is dropped

before trial and as much as $140,000 if the case actually goes to court, regardless of the merits.[11] So, even when good doctors win their lawsuits, which happens the vast majority of the time, they still lose. They lose valuable patient time, money, and peace of mind while watching their professional reputations impugned.

It is clear that no doctor is safe from lawsuit abuse, but as studies have shown, some are more vulnerable to abusive litigation than others because of their specialty or the location of their practice. Today, one-third of orthopedists, trauma surgeons, ER doctors and plastic surgeons will probably be sued in any given year.[12] Neurosurgeons face liability lawsuits more often – every two years on average.[13]

OB-GYN physicians are another favorite target of personal injury lawyers with nearly three out of five OB-GYNs sued at least twice in their careers. The American College of Obstetricians and Gynecologists (ACOG) 2009 Medical Liability Survey found nearly 91 percent of OB-GYNs surveyed had experienced at least one liability claim filed against them and sadly, we know most of the cases are without merit.[14]

Doctors in these specialties have not only faced the brunt of abusive lawsuits but, over the last decade, have seen their insurance premiums rise exponentially. While insurance premiums have leveled off recently or decreased slightly in some areas, they remain a serious burden for many doctors across the country. Moreover, with the implementation of the new health care bill, we may discover this has been a brief lull before the storm.

The excessive number of claims also has reached a plateau in the last couple of years, but the cost and size of the claims have not. In 2009, our most recent data, the average jury award escalated to almost $600,000 from about $280,000 in 1996.[15] Those kinds of payouts are even attracting the attention of investors, banks and hedge funds that are investing in medical liability lawsuits in hopes of a big payoff. Yes, medical lawsuit abuse has become one of the financial industry's latest hot tickets.[16]

Until Congress acts to stop what is, in reality, little more than legal harassment in most cases, doctors will remain in an untenable position, one that is forcing them to change the way they practice medicine, in large measure as a matter of self-preservation. That's not good for doctors, patients or the country's economic future. But they are trapped in a system that benefits lawyers, not patients. As Michelle Mello, a Harvard professor of law and public health, put it, "It would be hard to design a more inefficient compensation system or one which skewed incentives more away from candor and good practices."[17]

THE RISE OF DEFENSIVE MEDICINE – ASSURANCE AND AVOIDANCE BEHAVIOR

Today, "the fear of lawsuits is driving many providers to order tests and procedures that may serve mainly to protect themselves from predatory lawsuits." This practice of "defensive medicine" is a contributing factor in increased health care costs. Philip K. Howard, Chairman of Common Good, a legal reform coalition, said this in an April, 2009 *New York Times* opinion piece on defensive medicine.

> "The legal system terrorizes doctors. Fear of possible claims leads medical professionals to squander billions in unnecessary tests and procedures... Defensive medicine is so prevalent that it has become part of the standard protocol..."

For anyone concerned about reducing health care costs, keeping the deficit down and creating jobs, those words should set off alarm bells.

It's important to understand that defensive medicine isn't relegated to simply prescribing an extra test or two. Defensive medicine, in fact, has two major components: assurance behavior and avoidance behavior and each has consequences for patient care, and long term, for the public good.

Assurance Behavior Drives Increased Costs

Assurance behavior entails ordering tests, particularly imaging tests, but it might also include performing diagnostic procedures or referring patients for consultation in order to provide an extra layer of protection against abusive lawsuits -- and it is common practice. A June study in the *Archives of Internal Medicine* found nine in ten physicians said doctors engaged in assurance behavior ordering more tests and procedures than patients need in order to protect themselves against lawsuits.[18] While the estimated cost of lawsuit abuse varies, a 2006 study done by PricewaterhouseCoopers, estimated costs upwards of $210 billion a year.[19] The respected research firm found, "While the bulk of the premium dollar pays for medical services, those medical services include the cost of medical liability and defensive medicine... Defensive tests and treatment can pose unnecessary medical risks and add unnecessary costs to healthcare."

A more recent Gallup survey of American physicians found the fear of lawsuits was the driver behind 21 percent of all the tests and treatments ordered by doctors, which equates to 26 percent of all health care dollars spent. That comes to a staggering $650 billion.[20] According to a study of medical liability costs and the practice of medicine in *Health Affairs,* overuse of imaging services alone, driven by fear of lawsuits, costs as much as $170 billion a year nationally.[21]

Looking at state data, a study by the Massachusetts Medical Society revealed that 83 percent of the physicians surveyed reported practicing defensive medicine and that an average of 18 to 28 percent of tests, procedures, referrals and consultations and 13 percent of hospitalizations were ordered for defensive reasons. Estimates are that assurance behavior costs Massachusetts a staggering $1.4 billion annually.[22] Another study, this one in Pennsylvania, found 93 percent of physicians said they practiced defensive medicine.[23]

As sobering as these numbers are, they reflect an even bigger concern -- that what begins as a defense mechanism against lawsuit abuse becomes the standard of care, necessarily increasing its cost without an equal increase in patient benefit. Our nation simply cannot afford our current medical liability system.

Avoidance Behavior Threatens Access to Care

But assurance behavior is only part of the practice of defensive medicine. The second component is *avoidance behavior.* Physicians, especially in the target specialties, begin to restrict their practices and eliminate high-risk procedures or those procedures prone to complications such as trauma surgery, vaginal deliveries and brain surgery to name three. Physicians may also avoid patients with complex problems or patients they suspect might be litigious.

Over the years, a range of studies has shown both the financial and human costs of avoidance behavior. Forty-four percent of neurosurgeons have limited the type of patients they see and of these, 71 percent no long perform aneurysm surgery, 23 percent no longer treat brain tumors and 75 percent no longer operate on children.[24] Orthopedic surgeons, my specialty, are under similar pressures with similar outcomes. Fifty-five percent say they avoid certain procedures because of liability concerns. One in five has stopped emergency room calls, six percent don't perform surgery at all and one in twenty has retired early.[25]

Avoidance behavior will only lead to more doctor shortages particularly in high-risk specialties as young doctors reject these specialties in favor of lower risk medical fields that don't attract the attention of predatory personal injury lawyers and their lawsuits. The American Hospital Association has found that 55 percent of hospitals have difficulty recruiting doctors because of medical liability concerns.[26] Three out of four emergency rooms say they have had to divert ambulances because of a shortage of specialists and more than 25 percent lost specialist coverage due to medical liability issues.[27]

One emergency room physician was quoted as saying, "The lack of on-call specialists affects the numbers of patients referred to tertiary care facilities even for basic specialty related diseases (like orthopedics). This adds to emergency department crowding in some facilities, and it means that patients have to travel across town or greater distances for a relatively simple problem that could have been resolved if the specialist had been on call at the initial facility."[28]

Defensive Medicine Threatens Women's Health Care

Women pay an especially high price when it comes medical liability and access to care. "....the medical liability situation for ob-gyns remains a chronic crisis and continues to deprive women of all ages -- especially pregnant women -- of experienced ob-gyns," said Albert L. Strunk, M.D., deputy executive vice president of ACOG.[29]

ACOG's own data proves the point. According to their 2009 survey, 63 percent of OB-GYNs said they had made changes to their practice because of the risk or fear of liability claims. Between seven and eight percent have stopped practicing obstetrics altogether. In fact, ACOG found that the average retirement age of practicing obstetrics was 48. Once upon a time, before the medical lawsuit abuse crisis, that was considered mid-point in a doctor's career.[30]

Looking state by state, the picture is even more alarming. For example in 2007, Hawaiian women faced the harsh reality that 42 percent of the state's OB-GYNs had stopped providing prenatal care.[31] Dr. Francine Sinofsky, an OB-GYN in East Brunswick, N.J., says two of her practice's seven members no longer practice obstetrics due to the cost of medical liability. One who practices gynecology only pays $14,000 a year for liability insurance while another who practices obstetrics as well pays more than $100,000.[32]

In 2008, 1500 counties in America, eight counties in New York alone, didn't have a single obstetrician as liability issues chased good doctors out of obstetrics.[33] This shouldn't be happening in America -- to American moms and babies.

But the negative impact of lawsuit abuse on women's health goes beyond obstetrics. Today, the number of radiologists willing to read mammograms is shrinking, exacerbated by the decreasing number of medical residents choosing radiology as their specialty. The reason is simple. A failure to diagnose properly is the number one allegation in most liability lawsuits.[34] That makes radiologists the number one group of physicians affected.[35] Abuse of the litigation system is putting women at risk.

OUR HEALTH CARE FUTURE: FEWER DOCTORS AND MORE PATIENTS

As doctors, we want every American to get the quality health care they need. But the Patient Protection and Affordable Care Act, passed with the best of intentions last year, will likely make an already difficult situation worse as the demand for doctors increases and the supply, thanks in part to lawsuit abuse, fails to meet that demand. More than 30 million people may be added to the healthcare rolls in the next few years. Add to that an aging population and a toxic medical litigation environment and you've got a prescription for a significant shortage of doctors over the next twenty years.

The Association of American Medical Colleges (AAMC) has predicted that once the new health care reform provisions take effect in 2015, in just four short years, "the shortage of physicians across all specialties will more than quadruple to almost 63,000."[36] Another group, the American Academy of Family Physicians, has projected the shortfall of family physicians will reach 149,000 by 2020.[37]

AAMC also found the country will need 46,000 more surgeons and other specialists to meet demand in the next decade and that those living in rural or inner city locations will suffer the most severe impact. "This will be the first time since the 1930s that the ratio of physicians to the population will start to decline," according to Dr. Atul Grover, of the AAMC.[38]

A case in point is the access to care crisis in the state of Pennsylvania. According to a *Bucks County Courier Times* article in February 2009, 17 maternity wards had closed their doors since 1997 and the Philadelphia suburb of Chester County had no trauma

center to treat a half a million residents. As grim as those statistics are, they were only the tip of the iceberg.

Despite an outstanding medical education system, Pennsylvania's new doctors were choosing to leave to set up practice in states with friendlier liability environments. In 1992, 60 percent of residents stayed in the state when they finished medical training. By 2009, only 20 percent were willing to risk practicing in a state where liability reforms had languished.[39] Pennsylvania was also facing the hard fact that its specialist population was aging – more than 40 percent of its practicing physicians were over 50 – and younger doctors were either avoiding needed specialties or fleeing Pennsylvania's deteriorating liability climate.[40]

The current physician shortage Pennsylvania is experiencing is only expected to get worse. According to a University of Pennsylvania expert, Pennsylvania currently faces a shortage of 1,000 physicians – about 7 percent. Over the next decade, that shortage is expected to balloon to 20 percent, forcing Pennsylvania patients to drive further and wait longer for health care services.[41]

The Pennsylvania story and so many others like it around the country should be a wake-up call for anyone who is concerned about preserving access to quality care in America. Yet, the medical lawsuit system that has plagued the nation's health care providers for decades remains as a disincentive to physicians and a serious roadblock to real health care reform. Medical liability issues certainly aren't the only factors driving doctor shortages, but why maintain a system that we know is only adding to the problem?

If medical liability insurance premiums and litigation rates remain high, doctors will continue to be discouraged from entering the high-risk specialties our healthcare system will need in coming years. Defensive medicine is the antithesis of health care reform. It increases health care costs and has the potential to lessen the quality of care that we strive to provide our patients every day. But doctors are human. With the threat of predatory lawsuits hanging over their heads, defensive medicine will continue to be an understandable response until real reform is enacted.

Going Forward

There are remedies to fix this broken medical liability system, but it is imperative that we act now before defensive medicine practices and the costs that go with them become the standard of care. The good news is we know what works because the states have led the way forward with a proven track record of success across the country. Comprehensive medical liability reform that includes full compensation for economic damages (lost wages, medical expenses) and reasonable limits on non-economic damages ("pain and suffering") are reducing health care costs, attracting doctors to their states, strengthening the doctor-patient relationship and most important – preserving access to quality care.

I'd like to give you just a few good examples. The first is California, which has been a leader in medical liability reform for more than 30 years. The state's Medical Injury Compensation Reform Act (MICRA) has held down health care costs and improved access to care while protecting consumers' rights.[42] We believe MICRA is a good model for federal reform efforts.

In Missouri, liability reform has resulted in doctors' insurance premiums at 17 percent below those states without limits on non-economic damages and as of 2009, new medical liability lawsuit filings reached a 10-year low.[43] Alaska, another leader in liability reform, has the sixth lowest medical costs in the country along with strong expert witness laws that are keeping doctors where they belong – in the exam room, not the courtroom.[44]

Mississippi is yet another proof point when it comes to the positive effects of medical liability reform. Mississippi once was one of the country's hotbeds of lawsuit abuse. But in 2004, the state acted to create a hard $500,000 limit on non-economic damages and put other reforms in place to bring equity back to the liability system.[45] The results? The number of medical liability lawsuits fell by nearly 90 percent and physicians saw their liability insurance premiums decrease anywhere from 30 to 45 percent.[46]

But perhaps the most remarkable story of successful medical liability reform is the "Texas Miracle," an amazing turnaround for a state that once had the dubious distinction of being named one of the country's "judicial hellholes" by the American Tort Reform Association. But before Texas took steps to rein in runaway lawsuit abuse, it had earned the title. Doctors were leaving the state in droves and patients were the real losers. When it came to the number of physicians per capita, Texas ranked near the bottom, 48th out of the 50 states with just 152 MD's for every 100,000 people, far below the national average of 196.[47] Over a four-year period, Texas physicians were hit with insurance premium rate hikes of between 22.5 and 128 percent. Hospitals saw their rates more than double.[48] The litigation atmosphere had become so toxic that there were 300 lawsuits for every 100 doctors in some areas of the state.[49]

By 2003, the crisis was so severe the legislature took action to put limits on non-economic damages and to block the plans of personal injury lawyers to use the courts to overturn the legislation. The people of Texas then passed Proposition 12, a constitutional amendment that locked in the limits. The steady stream of doctors fleeing the state reversed and Texas was faced with a new "problem: "trying to deal with a big backlog in the state's licensing system.

The charts in the appendices following this testimony illustrate the positives outcomes that medical liability reform has brought to Texas. The number of liability filings dropped significantly and specialists who had been leaving the state saw dramatic increases in the years following reform.

Medical liability reform has led the state's largest insurers to lower rates, one as much as 31% and health care providers have seen more competition for their insurance business

as new firms have entered the market.[50] After passage of the liability reform in 2003, 82 counties have seen net gains in the number of emergency physicians. What has been especially heartening have been the increases in 43 medically underserved counties.[51] As I'm sure Chairman Smith knows, the Texas reforms became the basis for reform legislation introduced in the U.S. Congress in 2006.

MOVING TO A FEDERAL SOLUTION TO MEDICAL LAWSUIT ABUSE

We strongly believe that comprehensive reforms of the kind passed in Texas and California should be applied nationwide through federal medical liability reform legislation.

HCLA has outlined several legislative proposals that preserve state laws already working effectively to make the medical liability system fair for both patients and health care providers but also broaden coverage across the nation.

Among HCLA's proposed reforms are:

- Full compensation for all economic damages, but reasonable limits on non-economic damages
- A 3-year limit on the statute of limitations after the date of injury
- Limiting excessive attorney's fees
- Expert witness requirements
- More transparency in compensation
- Joint and several liability

In October 2009, the CBO responded to a request from Senator Orrin Hatch for an analysis of proposals to limit medical liability lawsuits in order to reduce health care costs and the practice of defensive medicine. The CBO wrote "more recent research has provided additional evidence to suggest that lowering the cost of medical malpractice tends to reduce the use of health care services." It found that if a package of reforms similar to those implemented in the states -- such as limits on noneconomic damages and other reforms -- was enacted at the federal level, it would reduce health care spending, lower costs and actually increase federal tax revenues. Together, this would mean a reduction in the federal budget of $54 billion over the next 10 years.

While the state-by-state approach to reform has paid dividends to some patients, it is clear that state liability reforms, including limits on non-economic damages, are always under the threat of legal action by personal injury lawyers looking to maintain a system that only serves to enrich them.

In many of those states where reforms are bringing the practice of medicine back into balance, personal injury lawyers have used the courts to attempt to overturn not only legislative liability reform but to subvert the will of the people who have voted for medical liability reform through ballot initiatives. Texas is a good example of a jurisdiction in which those efforts, thankfully, have failed so far.

Illinois wasn't so lucky when the State Supreme Court struck down reforms passed in 2005. Despite clear progress in terms of lessening the medical liability crisis while the reforms were in place, today the state's doctors find themselves back in the quicksand of lawsuit abuse. The same can be said for Georgia's doctors who lost their liability protections when the Georgia Supreme Court overturned the state's liability limits last year. Further, in states like Pennsylvania passing medical liability reform is proving to be particularly challenging. Meanwhile, patient access to care in that state continues to be threatened.

Overturning reforms isn't the only item on the trial lawyers' "to do" list. One of the most disturbing new initiatives is their attempt to dramatically expand the ability to sue doctors. The best example is a ruling by the Massachusetts State Supreme Court that reinstated a suit against a doctor for prescribing a blood pressure medicine to a patient who later struck and killed a pedestrian with his car.

The American people clearly understand the issue of liability reform and the motives behind the raft of lawsuits trial lawyers are bringing to stop reform in its tracks. The Health Coalition on Liability and Access poll done in October 2009 found that by a wide margin, 70 percent of Americans support full payment for lost wages and medical expenses *and* reasonable limits on awards for non-economic "pain and suffering." Sixty-eight percent of those polled also favor a law to limit the fees personal injury attorneys can take from an award or settlement.

We know medical liability reform works for patients and doctors. Who it doesn't work for are personal injury lawyers dependent on a failed system that puts profit ahead of patients and affordable, quality care.

Today, there is broad bipartisan support for liability reform. The U.S. House of Representatives has passed numerous bills that would help solve the problems that plague our tort system when it comes to both patients' rights and physician protections. Unfortunately, none of those reforms received Senate approval and despite mounting evidence in the states of the benefits of medical liability reform, last year's Patient Protection and Affordable Care Act (PPACA) did not do enough to address the situation.

In fact, legitimate concerns have been raised that PPACA creates new causes of action for medical liability lawsuits, thus potentially greatly increasing the number of liability claims that are filed. The potential harm done by a flood of new lawsuits arising under the Act only further demonstrates the need to fix our medical liability system before we are thrown back into the crisis from which we only recently emerged.

CONCLUSION

But it is a new day. We are encouraged that so many Members of the 112th Congress are committed to medical liability reform. And we want to work with this Committee and others in the Congress toward real medical liability reform through a federal remedy.

Unfortunately, the health care reform bill wasted the opportunity to move forward with real liability reform and the reason was clear. Former Governor and Democratic National Committee Chairman Howard Dean even admitted it. When asked in a health care town hall meeting he said, "The reason that tort reform is not in the bill is because the people who wrote it did not want to take on the trial lawyers...and that is the plain and simple truth."[52]

I'm here today to ask you on behalf of doctors, nurses, hospitals, and most importantly, patients to finish the job. Three hundred million Americans want and need a healthcare system that is both accessible and affordable.

Reform the medical liability system before we reach the crisis we know is coming. Before health care costs go higher, and unemployment along with it. Before defensive medicine and doctor shortages change the very nature of our healthcare system. Before it's too late.

I'd like to close by telling you about a wonderful physician practicing not far from here in Maryland, Dr. Carol A. Ritter. She is a graduate of the Medical College of Wisconsin and on her medical school application more than 25 years ago, she wrote of her desire to help the underserved through medicine. She studied to become an OB-GYN, but in 2004 gave up obstetrics because of sky rocketing insurance premiums – up 69 percent in 2002 and 33 percent in 2003. When her insurance hit $120,000 a year, she did the math and realized that the insurance bill amounted to 85 percent of her obstetrics income. She couldn't deliver enough babies to pay the trial bar's tab.[53]

Today, Dr. Ritter maintains a gynecology practice and still delivers babies, but not in the U.S. She travels to places like Honduras and Haiti and Bosnia where she joins in relief efforts helping women in these impoverished places get the obstetrical care they desperately need including delivering babies. Dr. Ritter says she does it for "the sheer joy" of doing what she does best but can't do in Maryland simply because she cannot afford the risk or the insurances rates. I would say to you today, ladies and gentlemen, that something is very wrong when a committed physician like Dr. Carol Ritter can't bring an American baby into the world for fear of a frivolous lawsuit.

You have the ability and the responsibility to help right that wrong. Thank you very much.

ENDNOTES

[1] "Liability Concerns: Trauma center closes: ERs gear up," Joelle Babula, *Las Vegas Review-Journal*, 7/4/02
[2] "Malpractice Methodology," Peter Orszag, *New York Times,* 10/20/10
[3] "This Week with George Stephanopolous," 8/30/09
[4] HHS news conference, 9/2/09
[5] "Making Patient Safety the Centerpiece of Medical Liability Reform, " Sen. Barack Obama and Sen. Hillary Clinton, *New England Journal of Medicine*, 5/25/06
[6] Rasmussen Research, 12/2/09
[7] PIAA Claims Trend Analysis, 2009
[8] TNSMI/Campaign Media Analysis/cmag 1/1/04-9/1/09
[9] "Medical Liability: A World of Difference," Amy Lynn Sorrel, *American Medical News*, 5/3/10
[10] Manhattan Institute's Center for Legal Policy study, 2008
[11] "Reviving Tort Reform," *Investor's Business Daily,* 11/15/10
[12] "Defending the Practice of Medicine," Richard E. Anderson, M.D., *Archives of Internal Medicine*, June 2004
[13] "Effective Legal Reform and the Malpractice Insurance Crisis," Richard E. Anderson, M.D., *Yale Journal of Health Policy, Law and Ethics*, December 2004
[14] American College of Obstetrics and Gynecologists Medical Liability Survey, 9/09
[15] Physicians Insurers Association of America *Claim Trend Analysis*, 2009
[16] "Lawsuit Loans Add New Risk for the Injured," Binyamin Appelbaum, *New York Times*, 1/16/11
[17] "Why Medical Practice is Off Limits," *Wall Street Journal,* 10/15/09
[18] "Physicians' Views on Defensive Medicine," Bishop, Federman, Keyhani, *Archives of Internal Medicine,* 6/28/10
[19] "The Price of Excess: Identifying Waste in Healthcare Spending," PricewaterhouseCoopers, 2008
[20] "Price: Cutting Medical Costs without Obamacare," *Washington Times*, 3/18/10
[21] "Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Care 11," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, 2003
[22] "Investigation of Defensive Medicine," Massachusetts Medical Society, 11/17/08
[23] "Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment," *Journal of the American Medical Association*, Volume 293, Issue 21, 6/1/05

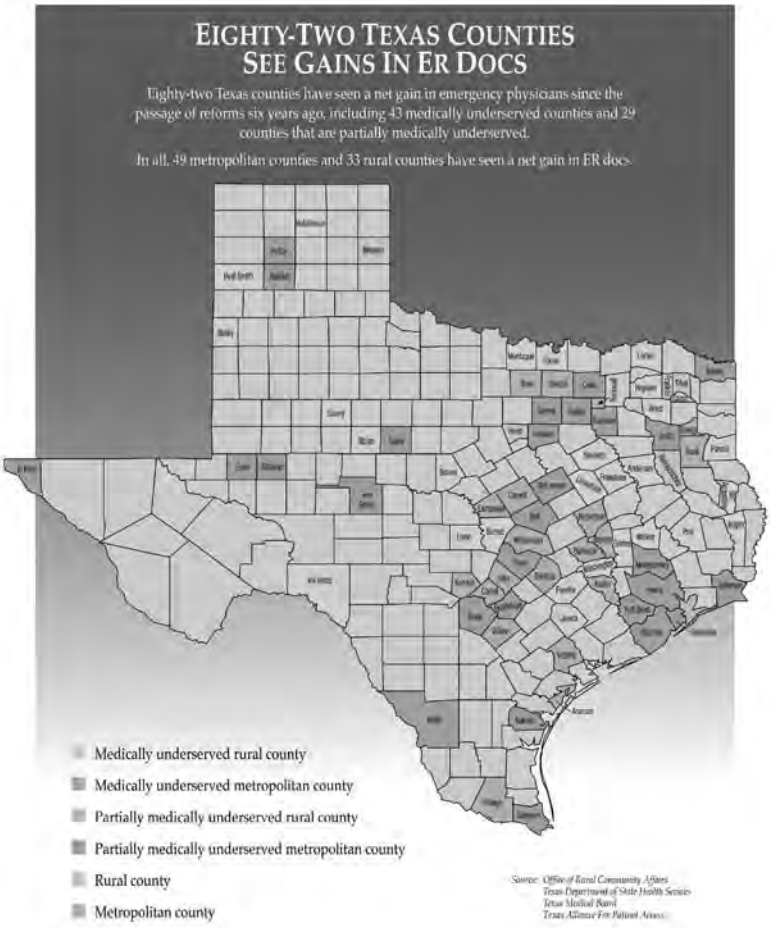
[24] "Federal Medical Liability Reform Survey," 2004, American Association of Neurological Surgeons and Congress of Neurological Surgeons, *Alliance of Specialty Medicine*, July 2005
[25] "Federal Medical Liability Reform Survey," 2004, American Association of Orthopaedic Surgeons, *Alliance of Specialty Medicine*, July 2005
[26] "Professional Liability Insurance: A Growing Crisis," American Hospital Association, March 2003
[27] Hospital Emergency Department Administration Survey, "Federal Medical Liability Reform," 2004, the Schumacher Group, *Alliance of Specialty Medicine*, July 2005
[28] "National Report Card on the State of Emergency Medicine," American College of Emergency Physicians, 2009
[29] American College of Obstetricians and Gynecologists (ACOG) news release, 11/3/06
[30] "Survey on Professional Liability, ACOG, 9/09
[31] "Doctors Urging Lawmakers to Support Tort Reform," *KGMB9.com*
[32] "The Doctor Drain," Lauren Otis, *The New Jersey Monthly*, 2/5/08
[33] "Center for Health Workforce Studies, cited in "no Place to be Born," *New York Sun*, 8/25/08
[34] AMA News, 3/20/06
[35] "Failure to Diagnose: Putting the Pieces Together, A Risk Management Review of Closed Claims in Selected Specialties 2002-2004," Linda Greenwald, Doctors' Insurance Services of New England, 2005
[36] Association of American Medical Colleges Center for Workforce Studies estimates, 9/30/10
[37] "Doctor Shortage Looms as Primary Care Loses it Pull," Janice Lloyd, *USA Today*, 8/18/09
[38] "Agencies warn of coming doctor shortage," Tammy Worth, *Los Angeles Times*, 6/7/10
[39] "Pennsylvania is Driving its Doctors Away," *Wall Street Journal*, 10/25/08

[40] Ibid.
[41] "Area facing a shortage in primary care physicians," *The (Pennsylvania) Daily Review,* 12/27/10
[42] NAIC Profitability By Line By State, 2005.
[43] "Malpractice lawsuits hit 10-year low in Missouri," American Medical News, 11/12/2009
[44] "Reviving Tort Reform," Investors Business Daily, 11/15/2010
[45] Mississippi Code Ann. § 11-1-60 (2007)
[46] "Mississippi's Tort Reform Triumph," *Wall Street Journal*, 5/10/08
[47] "A Miracle in the Making: How Texas Became a Model for Medical Liability Reform," Texas Tech Law Review
[48] Ibid.
[49] "Ten Gallon Tort Reform," Wall Street Journal, 6/6/03
[50] Texas Medical Association
[51] "Texas Alliance for Patient Access, 2010
[52] "Why Democrats won't cross the trial lawyers," *Washington Examiner*, 8/26/09
[53] "Maryland: A state in 'crisis' for ob.gyns," Mary Ellen Schneider, *OB-GYN News*, 10/15/04

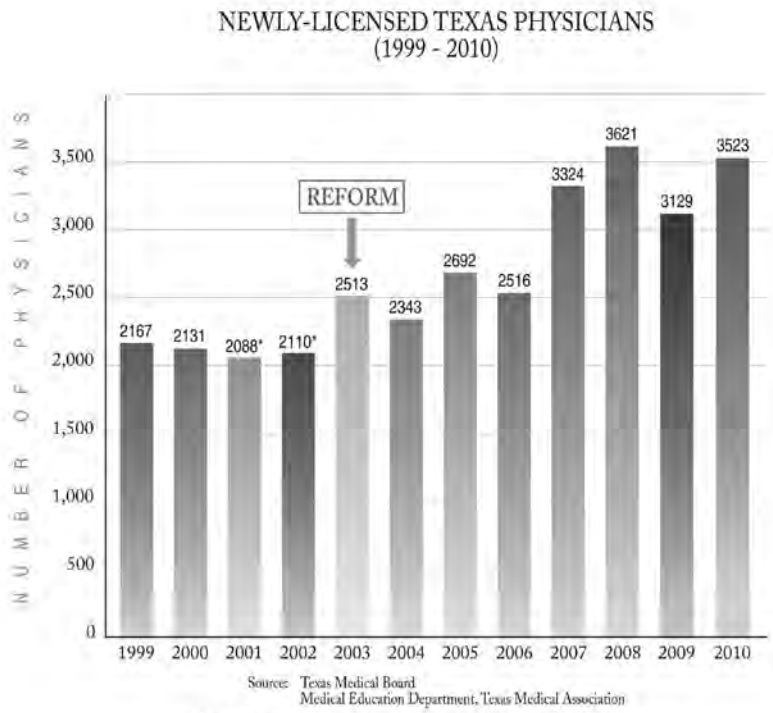
APPENDIX A:
99 TEXAS COUNTIES LOST AT LEAST ONE HIGH-RISK SPECIALIST
PRE REFORM: 2001-2003

APPENDIX B:
125 TEXAS COUNTIES ADDED AT LEAST ONE HIGH-RISK SPECIALIST
PRE REFORM: 2001-2003

APPENDIX C:
EIGHTY-TWO TEXAS COUNTIES SEE GAINS IN ER DOCS

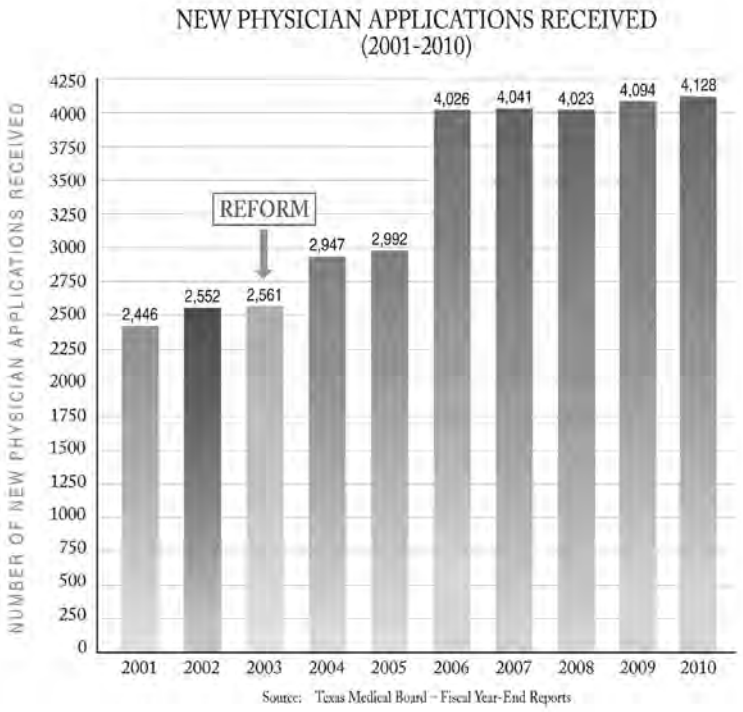


APPENDIX D:
NEWLY-LICENSED TEXAS PHYSICIANS (1999 – 2010)

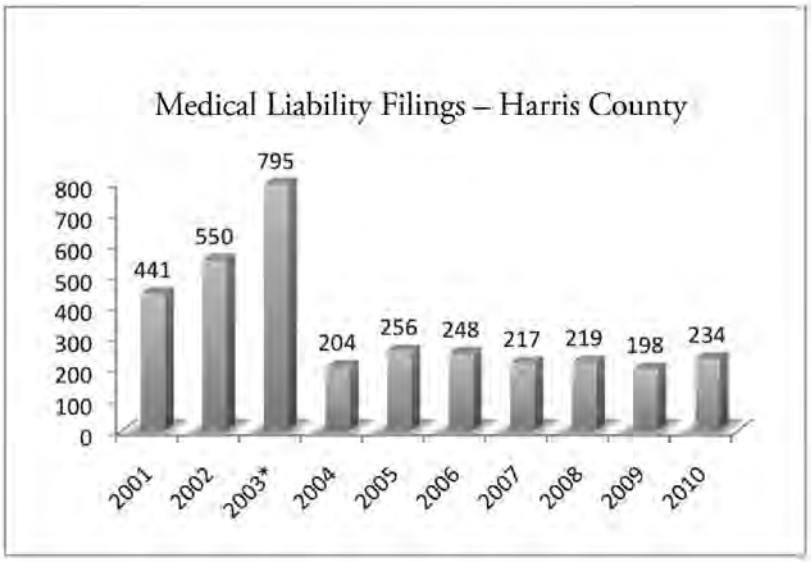


* In FY 2001, the Texas Medical Board meeting scheduled for late August was postponed until September 2, 2001, causing it in FY 2002. At that meeting, 703 initial licenses were issued and 17 licenses were reissued. The statistics have been adjusted based on the assumption that the group licensed in September (FY 02) would have been licensed in August (FY 01).

APPENDIX E:
NEW PHYSICIAN APPLICATIONS RECEIVED (2001 – 2010)



APPENDIX F:
MEDICAL LIABILITY FILINGS – HARRIS COUNTY



*Denotes rush to courthouse to beat effective date of new law

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Mr. SMITH. Thank you, Dr. Weinstein.

And I will recognize myself for questions and, Dr. Hoven, I would like to address my first question to you.

You heard mentioned a while ago and you know, of course, that the Congressional Budget Office estimates that we would save $54 billion over 10 years if we reduce the cost of defensive medicine.

There are other studies—for instance, the Pacific Research Institute says that defensive medicine costs $191 billion. A Price

Waterhouse Coopers study puts it at $239 billion. And Newsweek reports that, all told, doctors order $650 billion in unnecessary care every year.

I don't know which of those figures is correct, but they all point to the same direction, which is defensive medicine is expensive and costs, let's say, at a very minimum, tens of billions of dollars, probably, every year.

My question is this: Who pays for the cost of all that defensive medicine?

Dr. HOVEN. Thank you.

We all pay for the cost of that defensive medicine. At the end of the day, patients pay for it. We pay taxes that pay for it. We all pay, ultimately, for the cost of that defensive care.

Now, it is very important to realize, in the culture of fear in which we are all practicing medicine now—and I use that term because I think it is very real—that most physicians want to practice medicine the best possible way they can. They want to do the best job they can. But what they recognize is that their clinical judgment is not allowed to carry any weight in the court of law, so that, in fact, we do these things for assurance to protect ourselves. And, at the end of the day, that is where those costs do come around.

Mr. SMITH. Yeah, okay. Thank you, Dr. Hoven.

Dr. Weinstein, the Congressional Budget Office estimates that, if we were to enact medical liability reform, premiums would drop 25 to 30 percent. Who benefits from a drop in premiums of 25 to 30 percent? Or maybe I should say, is the benefit limited to the physician and medical personnel or not?

Dr. WEINSTEIN. I think, ultimately, Mr. Chairman, is that when medical liability premiums begin to drop, the culture of fear amongst physicians eventually will change. This is a cultural change that will have to occur over time. And once that cultural change occurs, then the practices of defensive medicine, which you have heard about over and over again, will eventually change, as well, and our health-care costs will go down. So, ultimately, patients and the American public will benefit.

Mr. SMITH. Patients and the consumers benefit.

My last question is to both Dr. Weinstein and Dr. Hoven. And I want to ask you all to respond to a point that Ms. Doroshow made, where she said that, basically, it wasn't medical liability reform that reduced premiums, it was insurance reform. And she gave the example of California.

Who would like to respond? Either California or Texas.

Dr. Hoven?

Dr. HOVEN. I will go first.

It takes 8 to 10 years to see the effects of these reforms when they are enacted. There really is not firm, hard evidence that, in fact, the insurance change was the result. It was the fact that, across the country, it takes 8 to 10 years to begin to see the evolution of change when these reforms are put in place.

Mr. SMITH. Okay.

And Dr. Weinstein?

Dr. WEINSTEIN. Mr. Chairman, I think that all would agree that the system in California compensates the patients in a much more

rapid fashion and also more appropriate, so that patients who are indeed injured get the majority of the reward.

Mr. SMITH. Okay.

And, Dr. Weinstein or Dr. Hoven, respond to this, if you would. In regard to the California insurance reform—I am looking at a newspaper article. It said that Proposition 103 that required a rollback of insurance premiums and not California's health-care litigation reforms have controlled medical professional liability premiums. That is the assertion. But, according to the Orange County Register, "A rollback under Proposition 103 never took place because the California Supreme Court amended Proposition 103 to say that insurers could not be forced to implement the 20 percent rollback if it would deprive them of a fair profit."

So it is hard to see the correlation, therefore, between the insurance reform and the drop in premiums. And, clearly, the drop in premiums were a result of the medical liability reforms.

I thank you all for your responses, and I will recognize the Ranking Member for his questions.

Mr. CONYERS. Thanks, Chairman.

And I thank the witnesses.

Where are we now in terms of the Health Care Reform Act, which sometimes is derogatorily referred to as ObamaCare—I use the term because I think it is going to go down historically as one of the great advances in health care.

But didn't the Health Care Reform Act, which still, by the way, is the law of the land and will be until the President signs the repeal, which I wouldn't recommend anybody to hold their breath on—we provided money for examining this very same subject, Section 10607.

Does anybody know anything about that here?

Yes, sir?

Dr. WEINSTEIN. Mr. Conyers, are you referring to the demonstration projects?

Mr. CONYERS. Yes, the $50 million for a 5-year period that—demonstration grants for the development to States for alternatives to current tort litigation. That is right.

Dr. WEINSTEIN. If I could address that question, I would say that the way the demonstration projects—which haven't been funded, I don't believe, yet—but the way the demonstration projects are outlined, I believe that the patients can then withdraw at any time and choose another alternative.

And I am a full-time educator/clinician scientist, and I would say, when you design a research study which allows patients to cross over or change, you don't get good information at the end of the day. That is not the good scientific method, if you will, if you want to find out what works best. So I would argue that the way that is designed has a flaw to it.

And, also, there have been demonstration projects across the States for a number of years.

Dr. HOVEN. If I could comment?

Ms. DOROSHOW. Could I——

Mr. CONYERS. Sure, you can.

Ms. DOROSHOW. Actually, in conjunction with that provision in the health-care bill, HHS has actually awarded, now, a number of

grants to many States, up to $3 million, to develop alternative procedures and other kinds of patient-safety-oriented litigation reforms.

So those grant proposals were already given; there was money. And these demonstration projects are in the process of being explored right now at the State level. I live in one State where that is true, New York.

Mr. CONYERS. Well, are we here—can I get a response from all of our witnesses about the whole concept of providing health care for the 47 million or more people that can't afford it? Are any of you here silently or vocally in support of a universal health-care plan?

Dr. HOVEN. If I may speak to that, sir?

Mr. CONYERS. Sure.

Dr. HOVEN. The American Medical Association recognizes that the PPACA is not a perfect bill, but it is a first step in getting us to where we need to be in this country—medical liability reform, alternative mechanisms for dispute resolution that are to be funded through that legislation are under way as we speak.

We in no way support a mechanism that does not recognize that every person in this country needs affordable care and access to quality health care.

Mr. CONYERS. Well, the bill that was just repealed yesterday provided for millions of more people getting health care because we raised the ceiling on Medicaid and we allowed the inclusion of children in the parents' health-care plan until age 26, a 7-year increase. Did that help any?

Dr. HOVEN. We will wait and see.

Mr. CONYERS. We will wait and see? You mean you will wait to see if there are any parents that want to keep their kids included for 7 more years? I haven't found one yet that doesn't want that provision in the bill.

Dr. HOVEN. Let me go back to my earlier comments. Access to care for everyone is what we want and need in this country.

Mr. CONYERS. Well, I know it. Yeah, that is a great statement. That is what I want, too. And that is why I was asking you about some of the provisions of the bill that was just dunked last night by the 112th Congress.

But I thank you, Mr. Chairman.

Mr. SMITH. Okay, thank you, Mr. Conyers.

The gentleman from New York, Mr. Reed, is recognized for his questions.

Mr. REED. Well, thank you, Mr. Chairman.

I thank the witnesses for appearing today.

I will ask Dr. Weinstein, when I looked at the National Commission on Fiscal Responsibility and Reform, the President's commission to explore ways to reduce the deficit, it was recommended in there that health-care litigation reform as a policy could save money and go to limit the deficit. The deficit is a huge issue and a priority for many new Members of Congress, of which I am one.

Do you agree that lawsuit reform could and would reduce the deficit?

Dr. WEINSTEIN. Yes, sir, I do. I think that has been shown. I think the CBO report that Senator Hatch had requested informa-

tion on showed it would reduce it by $54 billion over 10 years. And depending on what study you look at, I think there has been widespread discussion in the media, by Members of Congress, and also by various groups who have looked at this issue. Senator Kerry and Senator Hatch on "This Week" on ABC, I think, both felt that this would be a significant step forward, addressing the medical liability issue.

So I think that, to us, there is no question that this would, indeed, reduce health-care spending.

Mr. REED. Dr. Hoven, would you agree?

Dr. HOVEN. I most certainly would agree. I think, clearly, that is not chump change we are talking about. And we clearly need to move ahead. And, you know, that is a conservative estimate, and it may even be greater than that.

Mr. REED. And, Ms. Doroshow, would you agree or disagree with that?

Ms. DOROSHOW. I absolutely disagree with that.

I think that what CBO did unfortunately avoided a number of very important issues that will end up increasing the deficit, burdening Medicaid and Medicare, in particular—three things, in particular.

One is, when you enact these kinds of severe tort reforms, there are many people with legitimate cases that cannot find attorneys anymore and cannot bring cases. This is well-documented as having happened in California. In fact, you had a witness before this Committee in 1994 testifying to that effect. And it is certainly happening in Texas. So you have many people that are going to end up going on Medicaid that otherwise would have been compensated through an insurance company.

Second, as I mentioned, there are liens and subrogation rights that Medicare and Medicaid have when there is a judgment or a verdict in a lawsuit. In other words, they can get reimbursed. If there is no lawsuit, that reimbursement is gone. So they lose money in that regard.

Third, these kinds of measures are going to make hospitals more unsafe. There are going to be many, many more errors. Even the CBO, in its letter to Senator Hatch, talked about one study that would increase the mortality rate in this country by 0.2 percent. And that doesn't even include the injuries. So you are going to have more people hurt, more expense taking care of those people.

And, frankly, when you enact any kind of cap on noneconomic damages, in particular, those have a disproportionate impact on senior citizens, children, low-income earners. And, certainly, senior citizens, what has happened in Texas with the cap, those cases really are not being brought anymore. So senior citizens who are on Medicare, who should have a right to seek accountability from a hospital that caused negligence, no longer are bringing those lawsuits, and so Medicare is paying.

There are lots of costs that are going to end up increasing the deficit.

Mr. REED. Well, but my understanding is that we are not looking to discourage legitimate lawsuits. We are allowing economic damages to be fully compensated. And the subrogation rights that you refer to are derived from the economic damage calculation, because

those are lost wages—or medical bills, past and future, that the subrogation rights are derived from.

So what we are talking is focusing on the frivolous lawsuits that are there. So I guess I don't follow your logic saying that that is a reason why——

Ms. DOROSHOW. No, I think that is actually not what history shows. History shows, when you cap noneconomic damages, there are certain classes of cases that are no longer brought.

That is what has happened in California, and that is what this individual testified. An insurance defense lawyer testified before this very Committee in 1994: Entire categories of cases can no longer be brought, those that involve primarily noneconomic damages.

For example, one of the people we brought to Washington a couple of times, a woman named Linda McDougal, she was the victim of negligence——

Mr. REED. Thank you, Ms. Doroshow. I think my time has expired.

Thank you, Mr. Chairman.

Mr. SMITH. Thank you, Mr. Reed, for your questions.

Ms. Doroshow, if you want to finish the sentence, you may do so.

Ms. DOROSHOW. Well, she had an unnecessary double mastectomy because the lab misdiagnosed cancer when she didn't have it. And she came down to testify a few times. But her damages were entirely noneconomic in nature.

Mr. SMITH. All right.

Ms. DOROSHOW. So a cap only affected cases—her case.

Mr. SMITH. Okay. Thank you very much.

The gentleman from Virginia, Mr. Scott, is recognized for his questions.

Mr. SCOTT. Thank you, Mr. Chairman.

One of the problems we have in this discussion is a lot of the problems are articulated and then solutions are offered and very little effort is made to see how the solutions actually solve the problems.

Ms. Hoven, did I understand your testimony that physicians are routinely charging for services that are not medically necessary to the tune of $70 billion to $126 billion?

Dr. HOVEN. I am talking about defensive medicine.

Mr. SCOTT. I asked you, are those services that are not medically necessary?

Dr. HOVEN. They are services that are medically indicated and medically necessary if you look at guidelines and criteria. However, what does not happen is—my clinical judgment whether to employ that test is disregarded.

Mr. SCOTT. Are you suggesting that the services are not medically necessary? If liability were not a factor, would the services be provided or not?

Dr. HOVEN. It depends on the case. It depends on the situation. It depends on the environment of care.

Mr. SCOTT. And you are suggesting that in $70 billion to $126 billion worth of cases, services were rendered that were not medically necessary, were not needed?

Dr. HOVEN. That is not what I said, Congressman.

Mr. SCOTT. Well, what are you saying?

Dr. HOVEN. I am saying that health care delivered in the examining room, in the operating room, is driven by what is based on clinical judgment and based on assurance testing, which is documentation and proving that, in fact, that is what is wrong with a patient.

When we talk about cost control in this country, we are talking about the fact that—and this goes to the whole issue of cost containment, which is, if, in fact, you would recognize my medical judgment and allow me to decide when it is important to do a test or not, then our patients would be better served.

Mr. SCOTT. By not providing the services?

Dr. HOVEN. If, in my judgment, they don't need it.

Mr. SCOTT. And you are not able to—and you charge for services that, in your judgment, are not needed to the tune of $70 billion to $126 billion?

Dr. HOVEN. I do not do that. However, let me——

Mr. SCOTT. Well, I mean, your testimony was that physicians are charging $70 billion to $126 billion more than necessary and then blame it on liability. Now, is that your testimony?

Dr. HOVEN. Yes, that is my testimony.

Mr. SCOTT. That it is not necessary, that you are providing services that are not necessary. Either they are necessary or they are not.

Dr. HOVEN. We are practicing in a culture of fear. And that culture of fear lends itself to protecting oneself. I have been sued, Congressman. Let me tell you——

Mr. SCOTT. Wait a minute. I just asked you a simple question. You gave $70 billion to $126 billion. I just want to know what that represents.

Dr. HOVEN. That is costs for tests and procedures which, if you look at guidelines, would be medically necessary, but my medical judgment is discounted.

Mr. SCOTT. That, based on your medical judgment, should not have been provided.

Dr. HOVEN. Not necessarily.

Mr. SCOTT. Okay, well, I am not going to—Ms. Doroshow, if physicians are charging for services that are not necessary, how is that different from medical fraud?

Ms. DOROSHOW. That is a good question, because in order to get reimbursed—to file a claim with Medicare and to be reimbursed, physicians have to file a form and certify that the test and procedure, the services that they provided are medically necessary for the health of the patient. So it does raise a question whether or not some claims may be false.

Mr. SCOTT. If someone were to do a survey to say, why did you provide the services that were not necessary, what would be the convenient answer? If they ask you, why did you provide the services that were not necessary, what would be a nice, convenient——

Ms. DOROSHOW. To say that they——

Mr. SCOTT. Because they were afraid of lawsuits, so they can charge for services that weren't even needed.

Ms. Hoven, did you indicate that you supported a fair determination for medical malpractice issues, so that those who had bona fide cases could actually recover?

Dr. HOVEN. Most definitely, Congressman.

Mr. SCOTT. Now you are aware that the Institute of Medicine estimates about 100,000 deaths due to medical mistakes and only about 5,000 to 10,000 wrongful death cases are paid every year?

Dr. HOVEN. Well, if you look at the statistics, which you are obviously very familiar with, we are talking about apples and oranges here in many situations. We are talking about errors and adverse events as opposed to true malpractice and negligence. So I think you have to be careful about the terminology.

Mr. SCOTT. So what would be the barrier to 90 to 95 percent of the cases that were caused my medical errors from recovering?

Dr. HOVEN. They should be able to recover.

What the Health Act would do would allow them to recover so that they would be appropriately rewarded for what happened to them in their loss. The Health Act talks about that in terms of all of the economic elements that are involved, including their health care.

Mr. SCOTT. Mr. Chairman, my time has expired.

Mr. SMITH. Thank you, Mr. Scott.

The gentleman from Pennsylvania, Mr. Marino, is recognized for his questions.

Mr. MARINO. Mr. Chairman, I yield my time.

Thank you.

Mr. SMITH. We will go to the gentlewoman from Florida for her questions, Mrs. Adams.

Mrs. ADAMS. Thank you, Mr. Chair.

Ms. Doroshow, I was looking at this Institute of Medicine study. And you cited it in your opening statement and in your packet. And it says that as many as 98,000 patients die annually due to medical errors. And what we found was that it has shown to be exaggerated and unreliable, isn't that true, because based on, shortly after its release in 2000, the study came under heavy criticism for imprecise methodology that greatly overstated the rate of death from medical errors?

For example, the study data treated deaths from drug abuse as medication errors. And Dr. Troyen Brennan, the lead Harvard researcher who compiled much of the data upon which the report was based later revisited his methodology and determined that the actual figure could be less than 10 percent of the IOM's estimate. Is that true?

Ms. DOROSHOW. Well, what is true is that many other studies since then have found far more than 98,000 deaths; many other institutions that have looked into it. And, just in November, HHS took a look at this issue again, and they found that one in seven patients in hospitals are victims of an adverse event, and 44 percent of them are preventable.

Also, there was a study just also released in November of North Carolina hospitals—North Carolina is supposed to be a leader in patient safety—basically, finding that since the Institute of Medicine report, patient safety has not improved at all. And it really kind of shocked the authors of this research study, and they found

that the errors that are causing deaths and injuries are continuing at an epidemic rate.

So I would say that the 98,000 figure at this point is low and has been probably upped by every patient and government study that has looked into it since.

Mrs. ADAMS. So your testimony is that every adverse event is a medical malpractice?

Ms. DOROSHOW. I am looking at the studies and how they define it. In, for example, the HHS study, they found one in seven Medicare patients are the victim of an adverse event, and 44 percent are preventable.

Mrs. ADAMS. Again, are you saying, in your eyes, is an adverse event medical malpractice?

Ms. DOROSHOW. A preventable adverse event is.

Mrs. ADAMS. The other thing I wanted to know, I know who Dr. Hoven is representing and I know who Dr. Weinstein is representing. But I couldn't find in your documentation where the Center for Democracy and Justice gets its funding. Could you provide the Committee with a list of your fellow and associate members so we have an accurate understanding of the point of view which you are presenting?

And, also, you mentioned the demo projects and that they are going to get grant funding. Are you or anybody that is associated with the Center for Justice and Democracy able to apply for those grants?

Ms. DOROSHOW. Apply for which grants?

Mrs. ADAMS. The ones for the research that you were speaking about earlier.

Ms. DOROSHOW. Well, we are tiny. We have about five people on our staff. We are not a high-budget operation. So we don't really have the staff to do research projects like that. We hope other people would do that.

Mrs. ADAMS. Again, I would like to know, like your fellow and associate members, are they going to be applying for those grants?

Ms. DOROSHOW. Our associate members? I would have no information about any of that. I don't know. Those grants were already—that process has already taken place. HHS has already granted the money. In New York, for example, it granted $3 million to the Office of Court Administration in conjunction with the Department of Health that is looking at a specific proposal that was presented to them. So, actually, I know a lot about that proposal. I know about a few of the others. But that has already happened.

Mrs. ADAMS. Are you aware—and this goes to all three of you, and I think Dr. Weinstein and Dr. Hoven have said this, and I just want to make sure that you are aware also—that there are certain professions in the medical field that have stopped practicing because they can't see enough patients in order to cover their insurance costs, just the cost alone; not because they have done anything wrong, but they cannot see enough patients to cover their malpractice insurance costs.

Ms. DOROSHOW. Well, I hope that also you are aware that since 2006, we have been in a soft insurance market. That is why you don't hear any longer about doctors picketing on State legislatures and capitals and trauma centers, et cetera, that we did in the early

part of the 2000's, when we were in a hard insurance market, when rates were going up 100, 200 percent for doctors. This is a cyclical industry. This has happened three times in the last 30 years when rates have shot up like this.

To believe that the legal system has anything to do with it, you would have to believe that juries engineered large awards in 1975; and then stopped for 10 years; and then did it again in 1986 to 1988; and then stopped for 17 years; and then started up again in 2001. Of course, that has never been true. The claims have always been steady and stable.

So what is driving insurance rate hikes is the insurance and accounting practices of the insurance industry. The solutions to that problem lie with the insurance industry. They should not be solved on the backs of injured patients.

Mrs. ADAMS. I see my time has expired. I look forward to further discussion.

Mr. SMITH. Thank you, Mrs. Adams.

The gentlewoman from Texas, Ms. Jackson Lee, is recognized for her questions.

Ms. JACKSON LEE. Than you, Mr. Chairman.

Let me thank all of the witnesses for their presence here today. And I want you to know that each of your presentations are particularly respected and admired.

I want to start with the representative, Dr. Hoven, from the American Medical Association. Coming from Houston, I think many of you are aware, probably so for me, that we have one of the greatest medical centers in the world, the Texas Medical Center. I am very proud of a recent $150 million private donation just recently received by the Texas—by MD Anderson. And so I have a great familiarity with a lot of physicians and applaud their work and thank them for some of the lifesaving research that they have been engaged in.

But building on the present national law, which is, of course, the Patient Protection and the Affordable Care Act, Dr. Hoven, one of your peers or one of your colleagues who happened to serve in this body, Senator Frist, indicated that that law was the fundamental platform upon which we could now base our desire to go forward, to have additional provisions.

So I just want to get a clear understanding. It is my understanding the American Medical Association supported the bill. Is that correct?

Dr. HOVEN. The American Medical Association supported parts of the bill. We believe that access to care, covering the uninsured, decreasing costs and improving quality, are very, very important first steps.

Ms. JACKSON LEE. So you are telling me doctors would not support eliminating the preexisting conditions and allowing children to stay on their insurance until age 26?

Dr. HOVEN. We do support that.

Ms. JACKSON LEE. All right. So I think a great part of the bill, you did, and you probably would—I am not sure; maybe because you are before a large group that you don't want to say that the AMA supported it, but it is my understanding they did. I see some-

one shaking their head behind bill. So you support the bill. Did the AMA support the bill?

Dr. HOVEN. The AMA did support the bill. We have recognized it is an imperfect bill.

Ms. JACKSON LEE. You are absolutely right. And I will assure you, those of us who are lawyers as well agree with you, because it is very difficult to write a perfect bill. But as Dr. Frist said, this is a bill that is the law of the land. In fact, he even said he would have voted for it. So I want to clear the record that this is a bill that really does answer a lot of questions, but we can always do better.

Let me indicate to Ms. Doroshow, if I have it correctly, in the process of hearings, we have witnesses that represent the majority view. The majority is represented by Republicans, chaired by Mr. Smith. And we have a right to have a witness that maybe has a different perspective.

So to inquire of your funding, whether you are getting grants, every hearing we will find that we will have witnesses that agree with the predominant view of the majority, but we will also have in this democracy the right to have a different view.

I suppose you have a different view from the Health Act that is before us, is that correct? There is a bill—you have a slightly different view, is that my understanding, between this question dealing with tort reform or medical malpractice?

Ms. DOROSHOW. I certainly have a different view from the other witnesses, yes.

Ms. JACKSON LEE. That is the point I am making. So let me inquire.

And as I do that, I think the point that I wanted to engage with Dr. Hoven was to say that I want to find every way that we can work with physicians. I want their doors to be open. I want them to be in community health clinics. I want them to have their own private practice. I want them to be OB/GYNs. In fact, Dr. Natalie Carroll Dailey, an OB/GYN, former president of the National Medical Association, I count her as a very dear friend but also someone who counsels me.

So let me be very clear. Answer these two questions, to Ms. Doroshow: What is the reality of how many frivolous lawsuits we have? You have a notation of the Harvard School of Public Health. Give me that, quickly.

The second thing is, insurance companies. Isn't that the crux of the problem? Are the patients the ones that are charging doctors $120,000for insurance, or is it the insurance companies, who have documented that they will not lower costs even if there is a low count of medical malpractice lawsuits in that doctor's area, in that doctor's office, and in that State? Isn't that true?

Ms. DOROSHOW. Absolutely.

Ms. JACKSON LEE. Would you just comment very quickly. And let me, as I say that, say to you, my mother had a pacemaker for 20 years. She had a procedure to give her a new one. The next day she was dead.

I would like you to be able to answer my questions, if the Chairman would indulge your answer, please.

Ms. DOROSHOW. Well, in terms of the Harvard study, this is important because this is the study that gets, I think, misrepresented often and figures about 40 percent of the cases are frivolous.

Actually, the Harvard study found the exact opposite. In fact, I will read the quote from the author of that study, the lead author, David Studdert: Some critics have suggested that the malpractice system is inundated with groundless lawsuits and that whether a plaintiff recovers a money is like a random lottery, virtually unrelated to whether the claim has merit. These findings, the Harvard School of Public Health 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.

And there is a lot of extensive research done on that study. And the headline of the Harvard press release was: "Study Casts Doubt on Claims that Medical Malpractice System is Plagued by Frivolous Lawsuits." So that clearly is not a problem.

Mr. SMITH. The gentlewoman's time has expired.

Than you, Ms. Doroshow.

We will recognize the gentleman from Virginia, Mr. Forbes, for his questions.

Mr. FORBES. Thank you, Mr. Chairman.

And I want to thank all of our witnesses. I truly believe all three of you are here to do what you think is in the best interest of our patients and of the United States.

I feel the same way about the Members that we have up here. But we all have specific constituencies.

As much as I love the Chairman, I know that there are times that—he is from Texas, and he has a Texas constituency; the gentleman from Arkansas has an Arkansas constituency; and the gentlewoman from Florida has a Florida constituency. And that is why we tell everybody, the gentleman from Florida, the gentleman from Arkansas.

I think it is important that we know when you are testifying who you are constituencies are. And two of our witnesses have set that forward. And Congresswoman Adams asked what I think is a fair question to Ms. Doroshow, and that is if she would just be willing to give us your sources of public funding and your membership, would you make those public so we know who those constituencies are?

Ms. DOROSHOW. Well, we are a 501(c)3 tax-exempt organization, and we do not release the names and information about our donors. I will say that we get different kinds of funding. We get foundation grants, for example. In fact, I started the organization in 1998, and it was just myself sort of sitting there writing letters to the editor with a little bit of money from a friend of mine, and I got a large grant from the Stern Family Fund.

Mr. FORBES. Ms. Doroshow, I just only have 5 minutes. So the answer is that you won't let us know who your membership is and your sources of funding.

Ms. DOROSHOW. Absolutely not.

Mr. FORBES. Okay. Then we will take that into account. And let me just say that sometimes this is not as complex as we try to make it.

The reality is that everybody at home who watches these hearings and who looks at these issues, they know when you are talking about not changing tort reform who the true beneficiaries of that are. They are the trial lawyers. And the trial lawyers are the ones that put the dollars behind it. The trial lawyers are the ones that will sit here and tell us, if we don't do this, we are going to be impacted, and we are could be losing our jobs.

On the other hand, we know who some of the major beneficiaries are if we do tort reform, and that is some of our doctors. And they tell us, hey, if we don't do this, we could be losing our jobs.

One of the interesting things I can tell you and tell this Committee, I have never in my entire career had a single constituent walk into me and say, I am worried because I can't find a trial lawyer out there. But I have them over and over coming to me now, truly worried that they cannot find doctors to represent them. And, secondly, when I hear people talk about the 2 or 3 percent of bad doctors, that sometimes falls on hollow ground because the same people that will point and say, oh, yeah, we can't do malpractice reform because it is 2 or 3 percent of bad doctors fight us every time we try to get rid of the 2 or 3 percent of bad doctors, the same way they try to do when we try to get rid of the 2 or 3 percent of bad teachers.

So my question to you is this, all three of you. I am a firm believer in modeling and simulation. We use it in the Armed Services Committee to try to model for us our most difficult weapon systems, our military strategies. We are so confident in it, although we know it has some flaws, that we put the entire defense of the United States sometime on modeling and simulation that we can do.

Do we have any efforts at modeling and simulation that would help show us what the health care world would be like if we did tort reform and if we got rid of some of the litigation and whether it would benefit us or not? And if we don't, what can we do to help you move forward in that?

Dr. Weinstein?

Dr. WEINSTEIN. If I could address that question, I think you have a model out there existing already, and that is the most recent Texas reform. You also have California, which has a longer history.

And the Texas reform obviously showed lowering premiums but increasing numbers of critical care specialists, particularly in underserved counties. That included also pediatricians, emergency physicians, et cetera.

If I might, could I come back to the issue of the frivolous lawsuits? Is that possible.

Mr. FORBES. Absolutely.

Dr. WEINSTEIN. Congresswoman Adams asked about this. And I think the issues are that the data would be that 64 percent of suits are either withdrawn, dropped, or dismissed because they lack merit. Less than 1 percent are actually decided for the plaintiff.

And when you come to the New York study, which is called the Harvard study, that looked at New York data, you are talking about extrapolation of 280 cases of error. And in that study, errors could be someone falling in the hallway walking, and that was

lumped together with someone who had a significant surgical error. And the study has been flawed, as was pointed out.

Mr. FORBES. Dr. Weinstein, my time is up. I don't mean to cut you off, but I just wanted to say the point that you made about California and Texas is so accurate. We hear over and over we are going to do these demonstration projects, but you have two monstrous demonstration projects. And if we are going to ignore those, we are certainly going to ignore the other demonstration projects.

Dr. Hoven, I don't have time for you to give me your answer, but if you could submit it to us in writing.

Or, Ms. Doroshow, we would love to have it on the modeling simulation part.

Mr. SMITH. Thank you, Mr. Forbes.

The gentleman from North Carolina, Mr. Watt, is recognized for his questions.

Mr. WATT. Thank you, Mr. Chairman.

Let me first apologize to the witnesses. I had to leave to go to a meeting and didn't hear anything other than a small part of the first witness's testimony. But I assure you I will read it.

I didn't come back to ask questions about what you said because I didn't hear what you said.

I came back, really, to make sure that any perspective that I have on this issue gets into the record, because this is where I differ with a lot of my colleagues who have thought that this is an appropriate issue for us to deal with in the U.S. House Judiciary Committee.

I am kind of a States' rights old-school guy on this and have always believed that tort law was a matter of State law. I concede that we have the authority to write tort standards for Medicare recipients and for the range of people that we do. But general tort law, from my perspective, has always been a matter of State law.

I happen to live in Charlotte, North Carolina, and that is right on the South Carolina line, but I have never seen a hospital that straddles the line. They don't operate—I have never seen a medical procedure take place in interstate commerce. I concede they use stuff that comes through interstate commerce. Everything we do comes through interstate commerce. But I just think that this is an issue that my conservative colleagues, the States' righters, have lost their way on.

Were I a member of the North Carolina State legislature, perhaps I would listen very intently to whether we need to, in North Carolina, do tort reform. And they have at the State legislature level in North Carolina. I happen to think that they are as intelligent and bright in the State legislature of North Carolina as we happen to be here in the Congress of the United States. We don't have any monopoly on knowledge on this issue. It is a State issue. It has historically been a State issue. And I think my conservative colleagues have lost their way trying to make this a Federal issue.

So I want that in the record. They say I used to be the chair of the States' Rights Caucus on this Committee. Maybe this is one of those times that I got that reputation as being the chair of the States' Rights Caucus. But we can debate whether, State-by-State, States ought to be doing this. We could even debate whether we ought to be applying some different standards for Medicare recipi-

ents or Medicaid recipients. But I just think, as a general proposition, having a debate about doing general tort law reform in the Congress of the United States offends that Constitution that we read the first day of this session on the floor. So that is my perspective.

I appreciate you all being here as witnesses. But I didn't want to miss the opportunity to put that perspective in the record in public, not that I haven't done it before. If you go back to the 111th Congress, the 110th Congress, the 109th Congress, and you go all the way back to when I started, whatever Congress that was, I think I have given my perspective on this over and over and over again because we have been talking about this for the 18 years that I have been here. And my position on it hadn't changed.

We don't do malpractice interstate. If a doctor is operating on somebody that lives in another State, they can get into Federal court and apply whatever State law it is that applied in that jurisdiction.

So that is my story, and I am sticking to it.

Mr. LUNGREN. Would the gentleman yield for a moment?

Mr. WATT. I don't have any time left.

Mr. SMITH. The gentleman's time has expired.

Let me say to the gentleman, we appreciate his consistency over the years in being for States' rights and appreciate his being an original founder of the States' Rights Caucus on the Judiciary Committee.

I will now go to the gentleman from Arkansas, Mr. Griffin, for his questions.

Mr. GRIFFIN. Thank you, Mr. Chairman.

Dr. Weinstein, I am particularly interested in the Gallup Poll that came out in February of 2010. Over the last year or so, I have talked to a lot of doctors in my district who are advocates for some sort of medical liability reform. During the last year, this poll came out, and I was struck by the numbers. And I saw that you referenced this Gallup Poll in your statement.

The first question I have for you, is the data in this Gallup Poll, the one that came out in February, is it consistent with other data that you have seen, particularly the point that physicians attributed 26 percent of overall health care costs to the practice of defensive medicine; and then, secondly, that 73 percent of the physicians agreed they had practiced some form of defensive medicine in the past 12 months?

So my first question is whether that data in the Gallup Poll is consistent with data that you have seen elsewhere.

Dr. WEINSTEIN. Mr. Griffin, I think the data on the cost of defensive medicine vary considerably, from low estimates of $56 billion over 10 years to—this was the largest estimate—$650 billion. And you can go back to studies like Kessler and McClellan and others who have looked at it, and the costs of defensive medicine are astronomic. Physicians practice defensive medicine. It is not going away.

A very well-done study, not by doctors but by lawyers, this Harvard group, shows that 90-plus percent of physicians in the State of Pennsylvania practice defensive medicine. Whey they surveyed residents, doctors in training across all the residencies in Pennsyl-

vania, they found that 81 percent felt they couldn't be honest with patients. They viewed every patient as a potential lawsuit. And the most depressing statistic of all was 28 percent of residents across the spectrum in Pennsylvania regretted their choice of becoming a doctor because of the liability crisis.

Mr. GRIFFIN. With regard to the Pennsylvania data that you are discussing, have you turned that data over to the Committee?

Dr. WEINSTEIN. Yes, sir, that is in the written testimony, the reference to that.

Mr. GRIFFIN. What procedures—could you give us some specifics on the procedures that are usually subject to the practice of defensive medicine?

Dr. WEINSTEIN. Sure. Defensive medicine breaks down to two areas. One is assurance behavior. You need to assure yourself you haven't missed something. As has been pointed out by Dr. Hoven, in medical school, you are trained to take a history, do a physical examination, and try and put this puzzle together. Occasionally, you will need one test, a lab test or an imaging study, and then you will take it in an orderly progression.

But the climate of fear that exists from the medical standpoint is such that you need to keep taking that progression, that orderly progression, to the very end from the beginning because, should you miss something, your life and your ability to practice medicine and your craft is over. So that is the assurance behavior.

Avoidance behavior is most medical students come out of medical school with—in our school, it is over $100,000 in debt. So when they choose a career, they come out of our orthopedic surgery residency able to take care of anybody who is brought in off the highway who has had a traumatic injury and put them together again, but the majority of them don't want to do that. They don't want to cover the emergency room because that is a high-risk environment. So you avoid things that are high risk. You avoid OB. If you are a neurosurgeon, you don't take care of children head injuries. A doctor doesn't do vaginal deliveries or any deliveries at all. So that is how the avoidance behavior affects the American public.

Mr. GRIFFIN. So, getting down to the specific medical procedures that are usually subject to that, you mentioned head injuries; you mentioned OB/GYN. Can you get even more specific in terms of the actual procedures?

Dr. WEINSTEIN. Well, I think just head injuries in children. There are very few neurosurgeons willing to take care of a head injury in a child. At one time in this town, 40 percent of OB/GYNs weren't doing deliveries. This was a few years ago. One in seven OB/GYNs no longer just deliver babies. OB/GYNS now get, on average, get out of obstetrics at age 48, which would be a mid-career point. You are just reaching your peak. You have got another 20 years of practice. But now OB/GYNs stop practicing obstetrics at age 48 because of the liability risk.

Mr. GRIFFIN. If you have a number of tests that are being conducted using equipment and using resources and, in some instances, they are not necessary, they are more to assure or to avoid, can you comment on that crowding out tests that need to be conducted that are necessary?

Dr. WEINSTEIN. I think that when you crowd a system with—I won't say that they are unnecessary tests. The gentleman earlier was sort of implying that these tests are illegal that you are doing; you are defrauding Medicare. I think that is not the truth. But, basically, as I mentioned, when you progress to solve a puzzle in taking care of a patient, you follow an orderly progression. If this doesn't work, then we will do this study. We will do a CT scan or a myelogram or an MRI. But we can't afford to do that any more.

So what happens is you use valuable resources, imaging resources in particular, to do defensive medicine to take that step number 10 and bring it down to step number 2, and you deprive someone who actually needs that resource from the use of it.

Mr. GRIFFIN. So, if a young child who has a head injury comes into the emergency room, an ideal situation, you are saying a doctor would look at that child and say, well, I am going to start at step one. And if I think I need to go to step 2 on my way to 10, then I will do that progressively. But in the current environment, they see the child and they automatically say, we have got to do 1 through 10.

Dr. WEINSTEIN. Well, I think if there is a pediatric

neurosurgeon or a neurosurgeon willing to take care of that injury at that hospital, because I think three-quarters of our emergency rooms are at risk because of the availability or lack of availability of on-call specialists, that doctor will proceed with the entire battery from step one.

Mr. GRIFFIN. And not progressively.

Dr. WEINSTEIN. Not necessarily in an orderly, progressive fashion, which you learned in medical school.

Mr. GRIFFIN. Sure.

Mr. SMITH. Thank you. Mr. Griffin. I appreciate the questions.

The gentleman from Georgia, Mr. Johnson, who had the advantage of going to law school in Texas—is recognized for his questions.

Mr. JOHNSON. Thank you, Mr. Chairman.

Dr. Weinstein, it is a fact, is it not, that doctors are human beings?

Dr. WEINSTEIN. Yes, sir, they are.

Mr. JOHNSON. And it is also a fact that human beings are not perfect. Isn't it true?

Dr. WEINSTEIN. Absolutely.

Mr. JOHNSON. So doctors, just like human beings, make mistakes.

Would you disagree with that, Dr. Hoven?

Dr. HOVEN. Errors occur.

Mr. JOHNSON. Errors occur. Mistakes can be made. Isn't that true?

Dr. HOVEN. They can.

Mr. JOHNSON. By doctors. Correct?

Dr. HOVEN. That is true.

Mr. JOHNSON. And so now when a doctor makes a mistake, it can cause a death or it can cause a diminished quality of life in the victim. Would anybody disagree with that?

Hearing no objection or hearing nothing, I will assume that you agree with me on that.

That diminished life of a victim of what I will refer to as medical negligence, it has a value that a jury puts on it, and we call that noneconomic loss what, Lawyer Doroshow? What do we call that noneconomic loss, recovery for——

Ms. DOROSHOW. Permanent disability, blindness, disfigurement, mutilation.

Mr. JOHNSON. Pain and suffering for whatever may arise as a result of the doctor's negligence. Pain and suffering. Noneconomic loss. That is worth something, don't you think?

Now the question is, how much is pain and suffering worth? That might be a little different for Quanisha Scott who, back in Little Rock, Arkansas, in 2007, a 29-year old, went for a partial thyroidectomy to remove a goiter, and 12 hours later, she began to develop a shortness of breath and began feeling her neck tighten. Despite complaints to the nurses, her condition was not appropriately monitored or reported to a physician. She went into respiratory arrest and suffered severe brain damage. It was later discovered that she had a hematoma at the site of the surgery. She is now bedridden and totally dependent on her mother for care.

Now that is pain and suffering. Do you think that pain and suffering is worth more than an arbitrary cap of $250,000? If you do, I disagree with you.

If you think that Lauren Lollini out in Denver should be limited to $250,000 for pain and suffering—she went to a Denver hospital for kidney stone surgery in February of 2009. Six weeks later, her health began to deteriorate, with feelings of exhaustion and a loss of appetite. After a week of her illness, she became jaundiced and had an inflamed liver. The doctors at an urgent care clinic diagnosed her with hepatitis C. Thirty-five other patients became infected with hepatitis C at that hospital at the same time. A State investigation revealed that the outbreak began with a hospital staff person who used hospital syringes and painkillers during drug use.

Ms. Lollini is now convicted and sentenced to a lifetime of pain and suffering. How much is that worth? Is that worth $250,000? No. It is worth a whole lot more than that.

And what this legislation does is puts an arbitrary cap of $250,000 on noneconomic losses; pain and suffering. It is actually an affront to the United States Constitution, the 7th Amendment, which guarantees people a right to a jury trial when the amount in controversy is in excess of $20.

So, on one hand, we are talking about eliminating health care for everybody, and now we are talking about, 1 day later, we are talking about denying access to the courts for people who have been hurt.

That is about all I have got to say.

Thank you, Mr. Chairman.

Mr. LUNGREN [Presiding]. The gentleman's time has expired.

Next, the Chair recognizes Mr. Ross from Florida for 5 minutes.

Mr. ROSS. Thank you, Mr. Chairman.

Being from Florida, it is interesting, we did a little bit of research, and we saw that for an internal medicine physician, they pay as much as $57,000 for medical malpractice, but yet in Minnesota, they pay just a little bit more than $3,000, which makes you wonder whether the injuries are more severe in Florida than

they are in Minnesota or whether it is a result of the litigation environment.

And what I would like to do is just step away from the substantive part of what we have been talking about and not talk about damages or awards, but let's talk about the procedure. For example, in my practice, I will probably say that the vast majority of my cases have resolved at the mediation level. Whether it be court-ordered or voluntary, mediation seems to work.

And I guess, Ms. Doroshow, I would ask you, would you not agree that dispute resolution, as opposed to an actual trial, is more efficient, more effective in getting the needed benefits to the injured parties?

Ms. DOROSHOW. Ninety percent of cases do settle, but it is because of the threat of a jury trial, the possibility of a jury trial, that that happens. You take away the jury trial option, and that won't happen.

Mr. ROSS. I am not saying take away the jury trial, but I am also saying that when you are in the dispute resolution, a lot of factors come into play as to why you want to settle the case, whether it be because of the facts or the law. And in some cases, it is the burden of proof, is it not?

Ms. DOROSHOW. Well, the cases, the studies that I have looked at least, show that the cases that settle, there is negligence, there is error, there is injury. The cases that end up—the small number of cases that end up going to trial are the ones where it is a little more unclear, and they need a trial to resolve it.

So I think the system as it is right now is very efficient because most cases do settle. And that is really a system that really shouldn't be played around with. It is working now.

Mr. ROSS. But in terms of burdens of proof, I mean, different jurisdictions have like scintilla of evidence as opposed to clear and convincing. And that, would you not agree, that a burden of proof will be a factor that comes into play as to whether you want to settle a case?

Ms. DOROSHOW. For example, in Texas, for emergency room injuries, they made the burden of proof so incredibly difficult that it has knocked out all—every single emergency room negligence case. So what has happened there is the state of care in emergency rooms has become much more unsafe. And that is sort of what happened there. So, yeah, it does vary, and State law does determine that.

Mr. ROSS. Dr. Hoven, with the AMA, are there not practice protocols that physicians, groups, specialties, subscribe to in the performance of their duties?

Dr. HOVEN. Thank you for that question. Yes.

The AMA has been upfront going forward in many years, in fact, since the mid-1990's, in terms of measures, development, quality guidelines, outcome objectives. We have had a major role in this, and it has been applicable. And it is now standard of care. These guidelines are extremely useful in allowing us for evidence-based care.

Mr. ROSS. Not only extremely essential, but they sometimes lead to the practice of defensive medicine. In other words, if your practice protocol requires that if this diagnosis is made, then this form

of treatment is required; sometimes physicians may do that even though they may not need to just to stay within the realms of the practice protocols.

Dr. HOVEN. That is correct. And in fact, legislation needs to be out there that gives me, using my clinical judgment and my clinical knowledge, the ability to provide the best care for that patient at that particular point in time.

Mr. ROSS. Then, Dr. Weinstein, wouldn't you agree that if we had established practice protocols and we required by way of the funding of Medicaid or Medicare that it is contingent—the receipt is contingent upon established practice protocols in each jurisdiction and those practice protocols are followed—and the burden of proof would then have to shift from the physician to the plaintiff to show that by way of either clear and convincing evidence that they deviated from the practice and protocols or committed egregious error, would that not in and of itself provide a substantial reduction in the amount of litigation and the amount of awards out there?

Dr. WEINSTEIN. Well, I think that, first of all, all medical groups, including the AMA and others, have been working on guidelines, appropriateness criteria to help physicians establish a safer method of practice. But all patients don't fit in every single guideline. Patients are individuals. They have different comorbidities. And so they provide a general framework in which to start. But it is not a one-size-fits-all. Medicine is not like a cookbook that you follow this step and go this step. It has to be a physician interacting using their clinical skills to determine whether that guideline fits that particular patient or that appropriateness criteria needs to deviate for that.

Mr. ROSS. And in those cases where practice protocols are employed, should not the practicing physician have at least the defense that the burden of proof would now shift—that the doctor has established that he did the following protocols that were required of that particular specialty, and now there must be a showing by a greater weight of the evidence, clear and convincing evidence, that then the physician deviated from or committed egregious error.

Dr. WEINSTEIN. Well, I think—again, I am not a lawyer—I can only speak from a physician's standpoint—that the guidelines and appropriateness criteria are very good foundations for me as a practitioner to follow or to look at when I see an individual patient. But I have to use my skill and judgment acquired over, in my case, 35 years of practicing medicine, to decide if my patient fits exactly that paradigm. Otherwise, I need to have the ability to not have my hands tied. Otherwise, I am going to hurt my patient.

Mr. LUNGREN. The gentleman's time has expired.

The gentleman from South Carolina, Mr. Gowdy.

Mr. GOWDY. Thank you, Mr. Chairman.

Ms. Doroshow, I am going to ask you a series of what I hope are narrowly tailored questions in hopes of an equally narrowly tailored answer. Do you support any toughening of rule 11 sanctions for frivolous lawsuits, lawsuits that are dismissed or lawsuits where summary judgment is granted?

Ms. DOROSHOW. I think rule 11 is probably sufficient enough, but——

Mr. GOWDY. But you do not support a toughening of that?

Ms. DOROSHOW. No, I would prefer that to ever taking away the rights of victims and the clients——

Mr. GOWDY. I may not have phrased my question well, so forgive me for that. Do you support a toughening of rule 11 sanctions for frivolous lawsuits?

Ms. DOROSHOW. I think, obviously, I would have to see the provision. I don't have a problem with that, I mean, you know, in general.

Mr. GOWDY. So the answer is: You don't have a problem with that.

Ms. DOROSHOW. I don't have a problem with that.

Mr. GOWDY. You could support that.

Ms. DOROSHOW. Provided I looked at what you were asking me to support. That is a reasonable request.

Mr. GOWDY. How about this, how about joint and several liability reform. Do you support that or not?

Ms. DOROSHOW. Absolutely not.

Mr. GOWDY. Do you support a higher quantum of proof for emergency care?

Ms. DOROSHOW. Absolutely not.

Mr. GOWDY. Do you support any tort reform?

Ms. DOROSHOW. I support provisions that would repeal tort reform currently in existence in States, absolutely.

Mr. GOWDY. Do you support any tort reform?

Ms. DOROSHOW. For example?

Mr. GOWDY. Well, I just gave you four of them. We were 0 for 4.

Ms. DOROSHOW. I support a law that would prohibit confidential settlements where there are public health and safety issues involved. I would support that tort reform.

Mr. GOWDY. Dr. Hoven, many of us oppose the current health care law because, in our judgment, individual mandate is beginning to make the commerce clause so elastic as to be amorphous. For those of us that want to support tort reform, draw the nexus for us, draw the connection where it is an appropriate use of congressional power to supplant State tort laws, and while you are doing it, do we also surrender the States determining scope of practice issues if you federalize tort reform?

Dr. HOVEN. There is a role for both. The law we are talking about, the Health Act, in fact supports States in what they have already done and proffered and what they are putting into place. In States that don't have it, such as mine, Kentucky, we desperately need the Federal regulation, the Federal legislation to get us to a different place, for all of the reasons I have talked about before, which have got to do with access and cost.

So there is a role for both. But the Health Act recognizes that, I believe, and would achieve what we are looking for in the global topic of medical liability reform.

Mr. GOWDY. And when you say the Health Act recognizes that, you are referring specifically to the State flexibility provision that doesn't supplant current State law.

Dr. HOVEN. That is correct.

Mr. GOWDY. Is there any concern on behalf of physicians that if you allow congressional encroachment, if you will, into this area, that Congress will also want to decide scope-of-practice issues between ophthalmologists and optometrists and nurse anesthetists and anesthesiologists and other traditional State issues?

Dr. HOVEN. No. I mean, these are two separate issues. We fully recognize scope-of-practice issues. We deal with those; have been doing that for years and years. These are two different issues.

Mr. GOWDY. You don't think we lower the bar on the commerce clause at all by federalizing tort reform?

Dr. HOVEN. I trust you.

Mr. GOWDY. I am a lawyer. Don't.

Final question. Implicit—actually, more than implicit—in some of the questions that have been asked this morning have been very thinly veiled accusations of health care fraud, Medicare fraud, Medicaid fraud, for what we consider to be defensive medicine. Would you take a crack at explaining the predicament that physicians find themselves in with this culture of litigation and defensive medicine?

Dr. WEINSTEIN. Yes, I think that, as I sort of outlined before, as a physician, you have skills. History, physical examination. You put laboratory tests or imaging studies together to come and solve a puzzle for what is wrong with your patient or how to treat them. And then there is an orderly progression. If this turns out to be this way, I might go into in this direction or another direction. But what has happened is if you have this progression of multiple steps to get to the end, you don't stop at square one and say, let's see how it works; how does this treatment work; if they are not getting better, we will do something else.

What happens is, from the diagnostic standpoint, you do everything, because for fear that there is an adverse outcome or something happens, then you are at risk. So what happens is that the patient gets everything that is out there under the sun as opposed to just the stepwise progression toward an orderly either diagnosis or management plan.

Mr. GOWDY. I would like to thank all three panelists and thank you, Mr. Chairman.

Mr. LUNGREN. Thank you. The gentleman from Arizona, Mr. Quayle, is recognized for 5 minutes.

Mr. QUAYLE. Thank you, Mr. Chairman, and thanks to all of you for showing up. This is a very important topic if we are actually going to address and take control of our health care costs going forward. It is an important thing if we are going to have access to quality care.

My first question is to Dr. Weinstein. You state in your testimony that doctors in high-risk specialties have not only faced the brunt of abusive lawsuits but over the last decade have seen their insurance premiums rise exponentially. While some insurance premiums have leveled off recently or decreased slightly in some areas, they remain a serious burden for many doctors across the country. Moreover, with the implementation of the new health care bill, we may discover this has been a brief lull before the storm.

Can you expand on what you mean by the brief lull before the storm and why the insurance premiums might have been going off in a lull for a short amount of time?

Dr. WEINSTEIN. I think that we are in a lull, if you will, until we see how the Health Care Reform Act plays out and what happens here in this body and across the way. But I think that right now we need to look at the provisions of that and what actually becomes law, what actually is implemented, to see whether there are other avenues.

You know, just in the State of Massachusetts recently Lee the Supreme Court I think reinstituted a suit against a physician who had prescribed high blood pressure medication for his patient. That patient subsequently had an automobile accident where someone was killed, and now the physician is being sued for treating the patient's hypertension.

So there are always avenues that can be pursued by the trial bar. This is a very fertile area. The front page story of the New York Times in November showed how hedge funds and investment banks are investing in medical liability lawsuits. This is big money. This is big business. And it is unfortunate. But I think with the new health care law, we will have to see how things unfold and what happens as to what avenues are opened by that.

Mr. QUAYLE. And staying on that with the high-risk specialties, and if you look at the aging doctor population that is happening, you don't have many people going into the profession, and especially in those high-risk specialties, if we cannot actually control those liability insurance costs, how will that affect the quality of care for these different areas of expertise?

Dr. WEINSTEIN. When you lose high-risk specialties, I think every American is in danger when they have a problem—let's say in your State, Arizona, I think that was witnessed several weeks ago, unfortunately, but if you don't have the specialists available and have level one trauma centers available in a reasonable distance, you know, minutes matter. And I think the American public now can no longer expect that they could be traveling along a highway, have an accident, and expect they will go to an emergency room and be saved. That is an unrealistic expectation because of the shortage of high-risk specialists or, where there are high-risk specialists, their unwillingness to put themselves at risk by taking on high-risk cases.

Mr. QUAYLE. Do you know kind of the average, I mean, I know from talking to some people I know in the OB/GYN profession, it is over a $100,000 dollars, or in the area, just to turn their lights on. What is the average of some of those high-risk specialties?

Dr. WEINSTEIN. Well, I think the ranges are significant. It depends on the State, but I think, in some areas, even in high-risk spine surgery, for example, you are having physicians paying several hundred—$300,000, $400,000—in liability premiums. I can't tell you what the averages are. They are very high.

Mr. QUAYLE. Dr. Hoven, I was just wondering, there is an enormous financial toll on doctors when they have to defend frivolous lawsuits, but what is the emotional toll, and how does that affect the doctor-patient relationship for that doctor going forward?

Dr. HOVEN. It is very traumatic. Doctors want to heal, provide care, and take the best possible care. And when, all of a sudden, you are confronted with a lawsuit over which you have no control or you are part of something else in the suit process, it devastates you. I was sued. I tried to talk about that little bit ago. I was sued. For 5 years after that—and this goes to the issue of practicing defensive medicine—I refused to see—add any new patients to my practice. I found myself constantly thinking, what have I missed, what have I missed, what have I missed, even though I know I was bringing the best potential care there. This affects a physician's health. This affects their family's health. And most importantly, it begins to affect the relationship between the patients and the doctor, because all of a sudden, that threat, that fear of threat and trauma, is out there.

I consider myself a very good physician. And yet, in that process, I felt that I was damaged by the process.

Mr. QUAYLE. Thank you very much.

Mr. Chairman, I yield back.

Mr. LUNGREN. The Chair would recognize the Chairman from the Subcommittee that has jurisdiction over this issue, Mr. Franks from Arizona, for 5 minutes.

Mr. FRANKS. Well, thank you, Mr. Chairman.

Dr. Weinstein, I guess my first question would be to you, and perhaps, Dr. Hoven, you would follow up as well. Opponents of medical liability reform often argue, as you know, that reforming the medical liability system, especially through limiting noneconomic and punitive damages, will lead to the practice of medicine itself being less safe. I think that is a pretty critically important question to answer.

So, based on your experiences, do you believe that placing limits on noneconomic and punitive damages will affect whether doctors practice high-quality medicine or not?

Dr. WEINSTEIN. No, I don't, sir. It is pretty clear that the current system we have neither protects patients who are injured, nor does it make the system safer. We are not a country of infinite resources. And when you talk about economic damages, those can be quantified; whereas, you talk about noneconomic damages, there is no way those are quantifiable. And without infinite resources, it does not affect the quality of care of systems such as that.

Mr. FRANKS. Dr. Hoven, do you have anything to add?

Dr. HOVEN. Thank you. I would agree with the doctor's comments.

And I would also add that in this era, in the last 10 to 15 years, medicine, physicians have taken huge leadership roles following the IOM report, for example, in moving medicine to a different place, improving quality, improving systems, diminishing errors. So this discussion about physician responsibility and liability in this setting is difficult because we in fact have made major, major strides in improving health care throughout this country.

Mr. FRANKS. Dr. Weinstein, I thought one of the most striking pieces of your written testimony was your discussion of how our broken medical liability system disincentivizes doctors from entering certain medical specialties and discourages others from performing high-risk procedures or treating really high-risk patients.

How could legal reforms similar to the California's MICRA or the Health Act, which passed the House in 2003 here, positively affect a doctor's decision to practice in high-risk specialties or to treat high-risk patients.

Dr. WEINSTEIN. Well, I think with reasonable reform I think physician culture will change. Physicians will then feel it is worth the risk. There is always a risk when you talk about high-risk medicine. But it is worth the risk to be able to use the skills that you learned in your medical school and residency training and your fellowship training to help restore function, alleviate pain, and restore life to individuals. But unless reform such as those previous ones you have outlined is implemented that just won't happen.

Mr. FRANKS. Dr. Hoven, I have to tell you, just personally I am extremely grateful to the medical community because of having them have a tremendous impact on my own life. I had major surgeries starting out at birth. So I think that, you know, the importance of allowing doctors to pursue that calling that they have to try to help heal their fellow human beings is a profound significance in our society.

If I could ask sort of a hypothetical or just sort of ask you to reach out, if you could do one thing—and Dr. Weinstein I'll put you on deck, too. If you can answer it, it will be my last question. If you could do one thing in terms of public policy that we might pass that would strengthen the doctor-patient relationship, that would allow you as a doctor to work better with your patients and would also deliver the best care possible where you would protect both the patient and the doctor and the entire medical process in terms of liability reform, what is one thing you would do? What is the one priority that you would tell us, if you could only have one?

Dr. HOVEN. Thank you. Thank you for your comments.

And the answer to that is stabilization. The medical liability situation must be stabilized, and that stabilization includes addressing economic and noneconomic payments. It also has to remove from us in that stabilization the culture of fear and when somebody is looking over our shoulder all of the time. And that will improve and continue to enhance the patient-physician relationship. It will stabilize care in this country, it will improve access to care, and it will improve quality.

Mr. FRANKS. Thank you.

Dr. Weinstein.

Dr. WEINSTEIN. And I would say we need a rational solution to this situation. Because, right now, it is irrational. Nobody has benefited from it. And unless we do have some type of stability injured patients will not get compensated appropriately, and the system will never get better. Because system errors require a system of transparency, and you can only have a system of transparency when you have a stable situation where everyone can work together toward the same end of making a safer health care system.

Mr. FRANKS. Thank you all for coming.

Thank you, Mr. Chairman.

Mr. LUNGREN. The gentleman's time has expired.

The gentleman from Virginia, Mr. Goodlatte, is recognized for 5 minutes.

Mr. GOODLATTE. Ms. Doroshow, I would like to follow up on a question asked by the gentleman from South Carolina, Mr. Gowdy. One of the questions he asked you related to whether or not you would support a higher proof of negligence or substandard care for emergency care, and you said not just no but absolutely not.

So if we have—and all of us have at some time or another been in a theater, a sporting event, in a stadium or whatever where somebody becomes injured or ill; and the first question is, is there a doctor in the house. Now, you expect that doctor to identify themselves and come forward and help that individual. If they know very little about the circumstances, don't know what this patient's medical records are, previous history, treatment, what they might be allergic to, to try to save their life, you wouldn't provide a higher standard of protection for that doctor under those circumstances?

Ms. DOROSHOW. The standard is already pretty high. I mean, you're not finding lots of emergency room cases moving forward in this country. But when you do that—first of all, the emergency room, according to the Institute of Medicine——

Mr. GOODLATTE. But you would support—you would support a higher standard of——

Ms. DOROSHOW. No.

Mr. GOODLATTE. Well, that's the question he asked you—higher standard of negligence for somebody in an emergency situation.

Ms. DOROSHOW. Emergency rooms are the most unsafe and dangerous parts of a hospital. That is according to the Institute of Medicine. It is where many people go who don't have insurance.

Mr. GOODLATTE. How about a theater or a sporting event or somebody injured in an accident on the highway where a doctor happens to be coming by to provide assistance?

Ms. DOROSHOW. I believe that the civil justice system that exists in this country is able to handle cases that go forward based on the State common law that exists, that has been developed by the State. If the State common law—and, frankly, if the State decides——

Mr. GOODLATTE. Well, most—just reclaiming my time, most States have specific statutory liability provisions in addition to the common law.

Ms. DOROSHOW. Exactly. Look at Texas. What has happened in Texas is they have made the standard of liability for emergency room malpractice so high that it has knocked out virtually all cases. So you have a situation where a woman was in an emergency room, was misdiagnosed, as a result of that her legs have been cut off, and she cannot get an attorney.

Mr. GOODLATTE. Well, I am going to reclaim my time because it is limited and tell you that you are again avoiding my question.

Ms. DOROSHOW. I am not.

Mr. GOODLATTE. What about on the highway, in the theater, at the sporting event, out in public, away from a medical facility, if a doctor provides care, volunteers that care, under those circumstances, very different than an emergency room? But I agree an emergency room should be different than other standards of care as well. But in an emergency itself, should the doctor have greater protection?

Ms. DOROSHOW. I believe that the law should be what the State common law is right now.

Mr. GOODLATTE. I am going to go on to another question. Thank you.

Dr. Hoven, some argue that lowering a doctor's malpractice liability insurance bill does not really lower health care costs in a way that benefits patients. I don't agree with that. What are your views on it?

Dr. HOVEN. Well, I disagree with that statement as well. It is very clear that liability costs have to be something we can budget for and build into our costs of running a practice or a clinic. Money that I don't have to spend on liability insurance I can and do turn back into a practice to retain a nurse to provide care to 100 diabetic patients so that our costs are lowered. So I think that we have to be very careful in this phraseology. But, in actuality, if I can budget, I know what my monies are going to be, they are not out of sight, I can in fact improve care and quality and access to my patients.

Mr. GOODLATTE. Thank you.

And, Dr. Weinstein, Newsweek magazine reported that younger physicians are especially frustrated with practicing defensive medicine. Between rising insurance rates, increasing defensive medicine, and the regulations in bureaucracy in the new health care law, are you concerned that in the future fewer of our best young students will choose to pursue medical careers?

Dr. WEINSTEIN. Yes. I think the evidence there is very clear. And, again, this is borne out in the Pew Charitable Trusts study that was done by the Harvard Group and the

Columbia University legal team which shows that physicians in all residencies are discouraged, number one, to be doctors. Twenty-eight percent regretted even choosing medicine as a career. And that 81 percent viewed every patient they encounter is a potential lawsuit. I think this is a terrible state of affairs.

So there is no question that the younger generation is profoundly affected in their career choices, in their practice locations, and the context in which they practice, in other words, what they cut down their skill set to and what they are willing to offer the community in which they live.

Mr. GOODLATTE. They can spend a lot of years and hundreds of thousands of dollars to receive a license to practice medicine. And the cost then of liability insurance and the risk if they have to make a claim against that insurance or more than one claim against that insurance to their future as a physician, what is that risk?

Dr. WEINSTEIN. Well, I think the issue here is that you—there are plenty of people who need good medical care that aren't necessarily high risk. And if you feel you can have a satisfactory practice without putting your life and your family at risk by unnecessary liability many younger physicians are taking that route.

Mr. GOODLATTE. And that is indeed the crux of the problem, that the quality of medical care and the availability of medical care is very much affected by the perception of the medical profession and the reality to the medical profession of the current standards with regard to medical liability.

Dr. WEINSTEIN. Yeah. There is no question that access and quality of care are profoundly affected by the current situation.

Mr. GOODLATTE. Thank you.

Thank you, Mr. Chairman.

Mr. LUNGREN. [Presiding.] Thank you very much.

I will yield myself 5 minutes.

I come to this like everybody else does, as a product of my experience. I confess to you my dad was a doctor. He was a board-certified cardiologist and internist. He was chief of staff of Long Beach Memorial Hospital in southern California.

I was his wayward son. I went to law school, but I spent 5 years doing medical malpractice defense, although I did some plaintiffs' cases in southern California. My practice bracketed the time before MICRA and after MICRA; and for anybody to suggest that MICRA didn't make a difference, you weren't there.

I happened to be a young attorney at the time, and I had some classmates from high school and college who went to medical school, and they were about to enter the practice of medicine. And a number of them left the State of California because the insurance rates were so high. I remember a good friend of mine who is an anesthesiologist who left the State. Some OB/GYNs I knew left the State. Some doctors who were involved in brain surgery left the State because of the high costs.

I don't know where you get these figures that it wasn't until '88 that we saw any progress, because the absolute increase on a yearly basis of the premiums paid for by the doctors leveled off after we passed MICRA.

It was interesting to hear the gentleman from Georgia talk about the noneconomic damages. That is true. That is one of the key parts of MICRA. It puts a limit on noneconomic damages, pain and suffering. Why? Because that is the most potentially abused part of the system. I can prove losses for future earnings. I can prove what the costs are, the direct costs.

Pain and suffering, if you think about it, if before an instant you were to ask somebody how much would it be worth to you to lose your arm or your leg, they would probably say you couldn't pay me enough money to do that. After the fact, when you talk about pain and suffering it is a very difficult figure to determine. And so you make a rational judgment by the legislature or the people as to what that limit would be. Because, otherwise, it has an adverse effect on the potential for people having access to medical care.

I mean, it is not a perfect system. It never has been a perfect system. So I will just say from my standpoint, as someone who was there when we passed it in California, I saw a tremendous difference.

And then when people talk about frivolous lawsuits—let's talk about the real world. When a plaintiff's attorney files a lawsuit, begins the lawsuit, he or she sues everybody in sight because he or she can't be sure who was responsible. By the time you get to trial you ought to know as the plaintiff, plaintiff's attorney, who you think really is responsible and you ought to let out the other people. And if you don't we ought to have a very simple modified losers pay provision so that at the time of trial you can present to the judge and say if they have no case or they get less than what I am

offering now all attorney fees and costs should be borne by the plaintiff.

Because I was in settlement conferences where the judge would say to me, I know your hospital or I know doctor C doesn't have any liability, but the cost of defense will be $10,000, so throw in $10,000. And that was considered a, quote, unquote, settlement.

In every case I am aware of, you have that dilemma. And so when you are talking about even real cases of malpractice, a lot of other people are involved in the case and they may settle out, but there was no real liability. And unless you sort of change that dynamic you are going to have this situation.

So I have to overcome my reluctance to do this on a Federal level because I thought California, we were ahead of the rest of the country when we passed what we did. You probably couldn't have passed MICRA on the Federal level at the time.

But I am sorry my friend from North Carolina is not here because he said very clearly to me health care is not covered by the commerce clause. So I would hope that he would make that presentation before the courts that are considering the lawsuits right now.

So I am sorry I don't have any questions for you. Just listening to everything I have to put it into my sense of—no, he said if someone is not taken care of across the State border, they are in a hospital here or a hospital there, that is not interstate commerce—that is what he said—it is not covered by the commerce clause.

Anyway, but having heard all of this it brings me back to the arguments that we were making in California in 1974 and 1975. And we made a reasonable judgment in California. Frankly, I think it has worked very, very well. I think it is a model for the rest of the country. And I don't think there is any doubt that the specialties that are available in California are available in larger numbers today than they would have been had we not passed MICRA.

So there is no perfect system. I think we all recognize it. What we are trying to do is define that which will give us the best overall response to a continued problem. How do we meet our challenge? How do we provide health care for the people of the United States?

And the last note is I take my hat off to the medical community because I had major kidney surgery when I was four, I have had five knee surgeries, I have got a new hip, I have got a new knee, you repaired my Achilles tendon just a while ago. I am a walking example of what medical care can do for people in the United States. And my wife says, you are getting older; and I say, yeah, but I am getting new parts. So I just want to let you know, there is hope.

I would like to thank all of our witnesses for their testimony today.

Without objection, all Members will have 5 legislative days to submit to the Chair additional written questions for the witnesses which we will forward and ask you if you would respond to those please as quickly as you could so that we could make your answers a part of the record. If we send them to you, they will be serious questions from Members, some of whom weren't able to attend, some who had to leave, some who have more questions for you.

And I would thank you if you would seriously consider that, all three of you.

Without objection, all Members will have 5 legislative days to submit any additional materials for inclusion in the record.

With that, again, I would like to thank the witnesses. I know it is an imposition on your time. I know we have to run off and do votes and so forth and you sit here. But we thank you very much for your testimony. It is very, very helpful.

And with that this hearing is adjourned.

[Whereupon, at 1:15 p.m., the Committee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

PREPARED STATEMENT OF THE HONORABLE HENRY C. "HANK" JOHNSON, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA, AND MEMBER, COMMITTEE ON THE JUDICIARY

Congressman Henry C. "Hank" Johnson, Jr.
Statement for the Hearing on "Medical Liability Reform – Cutting Costs, Spurring Investment, Creating Jobs"

January 20, 2011

Medical malpractice is about real people, with real injuries, and real stories. Every year, thousands of Americans are injured because of medical errors. According to the Institute of Medicine, up to 98,000 people die each year in America from preventable medical errors.

Medical malpractice is a tort based legal claim for damages arising out of an injury caused by a health care provider. These laws hold a vital place in our society by compensating victims who have been injured by negligent health care providers. They serve as a deterrent to future careless behavior and contribute to the health and safety of the American public.

There have been occasions where individuals have left the hospital injured, bed-ridden, and paralyzed from botched surgeries and inaccurate diagnoses. Some patients are not even lucky enough to make it out alive after their health care provider performs carelessly.

In one specific instance, a woman went to the emergency room because she thought she had a kidney stone. The doctors discharged her and failed to diagnose her sepsis infection. When she returned to the hospital it was too late to treat the infection and both her feed and hands were amputated. The sepsis infection also left her blind in one eye. She was engaged, had three children, and was looking forward to a career as a civil servant. Now, she has to learn how to walk again and feed herself because of a doctor's careless behavior.

But my colleagues on the other side of the aisle are not necessarily concerned with improving the training of our doctors to ensure that these medical nightmares do not happen in the first place – they are concerned with attacking the medical malpractice laws we have in place and insisting on legislative proposals that would limit a victim's damages or access to the court house by placing caps on damages and contingency fees.

Past Republican proposals have included a $250,000 cap on non-economic damages. It is unreasonable to place a cap on non-economic damages. How can one place a price tag on one's pain and suffering, loss of a limb, or disability?

They have also included limiting contingency fees in medical malpractice cases. This is a real problem because these types of arrangements allow our most vulnerable victims – those who could not otherwise afford legal representation – access to the courts.

We all have a constitutional right, embedded in the Seventh Amendment, to a trial by jury where the damages exceed twenty dollars. Now is not the time to introduce legislation to chip away at that fundamental right or place obstacles in front of those who have suffered from horrific medical injuries.

Everyone makes mistakes. Doctors are human and are bound to make mistakes. When they do, the patients deserve to be protected. This is exactly what our medical malpractice laws seek to do – protect patients and deter negligent conduct.

Nonetheless, the Republicans want to clamp down on this type of litigation, justifying it by stating that frivolous lawsuits are behind the skyrocketing costs of health care. This is simply not true.

In 2009, out of every dollar spent on health care, less than half of one cent was spent defending claims and compensating victims of medical negligence. The estimated

number of medical injuries is more than one million per year, but only 85,000 malpractice suits are filed annually.

In 2005, the most recent U.S. Department of Justice data available, medical malpractice cases accounted for 14.9 percent of tort cases disposed of by trial in state courts nationwide. Patients prevailed in 22.7 percent of those trials.

A May 2006 New England Journal of Medicine study found that the majority of medical malpractice claims are legitimate, with 97 percent of claims involving medical injury and 80 percent involving physical injuries resulting in major disability or death. Thus, there is no concrete evidence that frivolous lawsuits are the cause of high health care costs.

Further, there is no solid evidence that malpractice payments increase malpractice premiums. To the contrary, tort reform caps have been shown to increase profits for insurance companies.

In fact, in states with caps on damages, malpractice premiums have increased. For example, California adopted tort reform where non-economic damages were limited to $250,000. Despite this, medical liability premiums in California actually increased by 190 percent during the first twelve years following enactment of the reform.

Moreover, even if the insurance companies were to save money because of tort reform, there is no evidence that those savings would be passed down in the form of lower physician premiums or health care costs.

In looking at medical malpractice reform, we must take a hard look at the highly profitable insurance companies and not punish patients by making it harder for them to recover damages after being injured by negligent health care providers.

Mr. Chairman, I thank the witnesses for being here today and yield back the balance of my time.

PREPARED STATEMENT OF THE HONORABLE LINDA T. SÁNCHEZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA, AND MEMBER, COMMITTEE ON THE JUDICIARY

Thank you for the time, Mr. Chairman.

I am discouraged that this is the first hearing this Committee is holding in the 112th Congress.

I'm not sure why the Majority feels the need to return to medical liability reform. This is a small problem – medical liability makes up only 0.5 percent of health costs in this country.

In fact, in the Chairman's own state of Texas, state legislators introduced very aggressive liability caps in 2003.

But in the years since, the cost of diagnostic testing in Texas has grown 50 percent faster than the national average and the cost of health insurance has more than doubled.

If medical liability reform were a practical solution to reducing health care costs, the Chairman's home state would prove it. I think we have our answer.

I am also discouraged by the witnesses invited by the committee. While I do not doubt their sincerity, I believe the Committee has "stacked the deck" in its invites.

If the Chairman is truly taking an open mind on this issue, then I would expect he will be holding future hearings which will include those who have endured the physical, psychological, and emotional pain that can result from a doctor's negligence.

We all know that no lawsuit or monetary award can compensate anyone for a lifelong injury, or worse, the loss of a loved one.

But our courts, at least, can give victims a sense of justice, and an acknowledgment that they have been wronged.

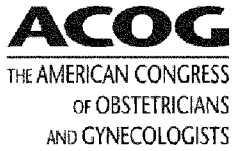
Stripping victims of the right to sue or placing arbitrary limits on damages does nothing more than cause a second injury to people who are already the victims of a physician's negligence.

I also believe whether a person receives damages for his or her injuries should be determined by a jury, not members of a legislature who have absolutely no knowledge of a particular patient's case.

My colleagues on the Republican side often speak about examples of government intruding in their lives – I believe medical malpractice caps also an area where we should all agree more government regulation is not the answer.

Thank you and I yield back.

PREPARED STATEMENT OF THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG)



A Statement By

The American Congress of Obstetricians and Gynecologists

to the

Committee on the Judiciary
United States House of Representatives

Medical Liability Reform
Cutting Costs, Spurring Investment, Creating Jobs

January 20, 2011

Washington, DC

Thank you, Chairman Smith, for holding this important hearing, entitled "Medical Liability Reform - Cutting Costs, Spurring Investment, Creating Jobs,"and for giving the American Congress of Obstetricians and Gynecologists (ACOG), an organization representing more than 54,000 physicians dedicated to improving the health care of women, an opportunity to present our views.

Our Nation provides exceptional medical education, training some of the world's finest obstetricians and gynecologists. Yet, 90% of ACOG Fellows report they have been sued at least once. On average, ob-gyns are sued 2.7 times during their careers, and nearly 63% have changed their practice during the last three years because of the high risk of liability claims. 35% have either decreased the number of high-risk obstetric patients treated or have ceased providing obstetric care altogether; 29.1% increased the number of cesarean deliveries; and 25.9% stopped performing or offering VBACs due to professional liability concerns. The average age at which physicians cease practicing OB is now 48, an age once considered the midpoint of an ob-gyn's career.

Without reform of America's broken liability system, women will increasingly find that they cannot get the prenatal and obstetric care they need, and many pregnant women will not be able to find doctors to deliver their babies. Women will lose care that will help protect fertility, end pelvic pain, and detect and treat cancer early.

I. The Need For Reform

In 2002, the non-partisan Institute of Medicine reported that

> "*The current liability system hampers efforts to identify and learn from errors, and likely encourages 'defensive medicine". Many instances of negligence do not give rise to lawsuits, and many legal claims do not relate to negligent care. ... Volatility in liability insurance markets has led to... closure of practices and shortages of certain types of specialists and services. The committee believes that changes in the liability system are a critical component of health care system redesign."*

Our current tort system is costly, time-consuming, inefficient, and unjust, with widely variable and inconsistent monetary judgments awarded by lay juries to injured patients. It cannot accurately distinguish bad outcomes from genuine negligence and it has the potential to devastate the practice of obstetrics. The system is wholly incompatible with the Institute of Medicine's vision of the future health care system as "safe, effective, patient-centered, timely, efficient, and equitable."

The Financial Burden on a Few "High-Risk" Specialties.

In childbirth, there is never a guarantee of a perfect outcome, even for patients who receive perfect ob-gyn care. Obstetrician-gynecologists are faced daily with exposure to lawsuits for adverse events over which they had no control – unfortunate outcomes, rather than malpractice -- with jury awards that exceed $100 million. It takes years to settle and adjudicate cases, delays are onerous, and the costs of defending oneself are enormous. It has been estimated that patients

who eventually receive compensation through the current system obtain less than 50% of the amount awarded. The remainder goes largely to the plaintiff's lawyer and court expenses.

The costs of the current tort system are borne by all obstetric caregivers -- nurses, residents, attending MDs, CNMs, and even medical students -- and the hospitals where they work, through the escalation of medical liability premiums. This contributes to a reduction in obstetric care by those currently practicing and in the number of American medical school graduates choosing to enter obstetric residency programs. As a consequence, the quality and availability of care for future generations of women in this country is threatened.

A National Problem Demands a National Solution.

A majority of states continue to perpetuate a system that is needlessly expensive, inefficient, and often inequitable, while year after year rejecting significant efforts to rectify its flaws. The federal government can break the logjam. A national solution would stabilize the medical liability insurance market, reduce health costs, eliminate physician flight from high-risk states, and protect patients' access to needed health care. The federal government should provide adequate funding and other resources to states and health systems to test innovative solutions to a broken liability system as recommended by the Institute of Medicine.

Defensive Medicine

Even though a very high percentage of liability claims are dropped, settled without payment or settled in favor of the defendant in court, the effect of fear of litigation is significant. Recent ACOG surveys show that obstetricians are performing more cesarean sections, discontinuing vaginal births after c-section (VBAC) attempts, decreasing the number of high-risk patients they are willing to care for, decreasing the total number of deliveries they do in a year, or discontinuing obstetrics entirely due to the current liability climate.

Patient Safety and Quality of Care

Meaningful reform of our broken liability system, in addition to reducing and stabilizing malpractice premiums, can make medical care safer and reduce medical errors. To further quality, comparative effectiveness medical research should take into account the role of medical liability laws in driving up health care costs and influencing practice patterns and behavior including defensive medicine. The liability climate should also be considered when assessing large variations across the country in prematurity rates and cesarean section rates.

II. A National Solution: H.R. 5 – The HEALTH Act

ACOG has for many years advocated reform of our broken medical liability system, including caps on non-economic damages, and other reforms like those found in Texas and California. We fully support H.R. 5, The HEALTH Act, soon to be introduced by ACOG-member Rep. Phil Gingrey, MD (R-GA), which would safeguard patients' access to health care and address the health care crisis.

Promotes Speedy Resolution of Claims

The Act balances the needs of all parties involved in litigation and promotes a fair result. Health care lawsuits can be filed no later than 3 years after the date of injury. Additionally, the bill acknowledges that in some circumstances, it is important to guarantee patients additional time to file a claim. Accordingly, the Act extends the statute of limitations for minors injured before age six.

Fairly Allocates Responsibility

Under the current system, defendants who are only 1% at fault may be held liable for 100% of the damages. This bill eliminates the incentive for plaintiffs' attorneys to search for "deep pockets" and pursue lawsuits against those minimally liable or not liable at all.

Compensates Patient Injury

HR 5 ensures injured patients are fairly and fully compensated. The Act does not limit the amount a patient can receive for physical injuries resulting from a provider's care, unless otherwise determined by state law. The Act only limits unquantifiable non-economic damages, such as pain and suffering, to no more than $250,000.

Maximizes Patient Recovery

Patients will receive the money needed for their health care. HR 5 discourages baseless lawsuits by limiting the incentive to pursue merit-less claims. Without this provision, attorneys could continue to routinely pocket large percentages of an injured patient's award.

Puts Reasonable Limits, Not Caps, on the Award of Punitive Damages

The Act provides for reasonable punishment without unnecessarily jeopardizing a defendant's fundamental constitutional rights or risking the defendant's bankruptcy. It does not cap punitive damages, rather, it delineates a guideline, allowing for punitive damages to be the greater of two times the amount of economic damages awarded or $250,000.

Ensures Payment of Medical Expenses

HR 5 ensures that injured patients will receive all of the damages to which they are entitled in a timely fashion without risking the bankruptcy of the defendant. Past and current expenses will continue to be paid at the time of judgment or settlement while future damages can be funded over time through the purchase of an annuity or other instrument of secured payment.

Allows State Flexibility

The HEALTH Act establishes a ceiling on non-economic damages, and guidelines for the award of punitive damages, only in those states where the state legislature has failed to act. A state

legislature may also act at any time in the future to impose a cap the limits of which differ from those provided for in the HEALTH Act.

ACOG applauds Dr. Gingrey for his continued committed leadership to keeping the need for medical liability reform at the forefront of our Nation's attention. We urge this Committee and the US House to give HR 5 speedy approval.

III. Alternatives to Current Medical Tort Litigation

ACOG is fully committed to the enactment of a national law, patterned on HR 5 and the Texas and California medical liability reforms. Only these solutions will fully and meaningfully solve this problem.

While we work to attain that goal, we support interim measures that address the long delays, excessive costs, and unpredictability and inequality of compensation in our current system. Successful alternatives could help guarantee that injured patients are compensated fairly and quickly while promoting quality of care and patient safety.

Early Offer

Early offer programs would allow a physician or hospital to offer economic damages - past, present, and future - to an injured party without involving the courts. This offer would not constitute an admission of liability and would be inadmissible if a lawsuit was filed in the case. Physicians would have incentives to make good faith offers as early as possible after the injury is discovered and patients would have incentives to accept legitimate offers of compensation. Early offer programs would require the injured party to meet a higher burden of proof and negligence standard if she chose to reject the offer and file a lawsuit.

Health Care Courts

Health care courts would allow for a bench or jury trial presided over by a specially trained judge to exclusively hear medical liability cases. A judge with specialized training would resolve disputes with greater reliability, consistency, and efficiency than untrained judges or juries, and could issue opinions that define standards of care or set legal precedent. De-identified claims information would enable patient safety authorities and providers to examine and correct patterns of errors.

Expert Witness Qualifications

This alternative would limit expert witness standing only to individuals who are licensed and trained in the same specialty as the defendant, have particular expertise in the disease process or procedure performed in the case, were in active medical practice in the same specialty as the defendant within 5 years of the claim, or taught at an accredited medical school on the medical care and type of treatment at issue.

I'm Sorry

These programs encourage physicians to directly discuss errors and injuries with a patient, apologize, and discuss corrective action. The apology is not permitted to be constructed as, or offered as evidence of, an admission against the physician's interest. Discussions are inadmissible if the patient brings a lawsuit.

Defined Catastrophic Injury Systems

These systems would establish a fund for individuals with bad outcomes regardless of fault. Birth injury funds are an example. Florida's program supports children born with substantial, non-progressive, neurologic motor deficits not caused by genetic or metabolic conditions.

Certificate of Merit

A certificate of merit program would require plaintiffs to file an affidavit with the court showing that the case has merit before the case can move forward. Certificates would require the written opinion of a qualified health care provider affirming that the defendant failed to meet the standard of care exercised by a reasonably prudent health care provider, which caused or directly contributed to the damages claimed.

IV. Conclusion

Thank you again for the opportunity to provide this statement to the House Judiciary Committee on the issue of medical liability. We applaud your commitment and leadership on this issue, Chairman Smith, and look forward to working closely with you and the Committee.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF SURGEONS

Statement
of the
American College of Surgeons

Submitted to
Committee on the Judiciary
United States House of Representatives

RE: Medical Liability Reform - Cutting Costs, Spurring Investment, Creating Jobs

January 20, 2011

American College of Surgeons
January 20, 2011

The American College of Surgeons (the College) is pleased to submit a statement for the record of the Committee on the Judiciary's hearing entitled "Medical Liability Reform - Cutting Costs, Spurring Investment, Creating Jobs". Medical liability reform continues to be a significant priority for the College and its members. For more than a decade, many Fellows of the College and their group practices have seen their liability insurance premiums skyrocket, regardless of whether or not they had ever been the defendant in a lawsuit.

In a growing number of states, surgeons are having difficulty obtaining medical liability insurance and, for those who are able to find coverage, the cost is often prohibitively high. Many surgeons are being forced to retire earlier, stop doing high-risk procedures or move to states where there are strong medical liability reforms. Surgeons in some areas are experiencing double- and even triple- digit premium increases every year. At the same time, reimbursements from Medicare and other insurers are declining, providing no way to offset the continuing escalation in premium costs. This situation has at times forced practices to borrow money in order to pay malpractice premiums.

In addition to the economic impact that premium increases have on practice finances, they can also affect the ability of surgeons to care for patients. Individuals may be forced to limit their practice and stop performing higher risk procedures because of the increased liability costs. Patient access to surgical care would be tested if, for example, bariatric surgeons no longer performed gastric bypass operations or obstetrician-gynecologists decided to stop delivering babies.

For many years, the College has advocated the federal adoption of health care liability reforms like those enacted in California under the Medical Injury Compensation Reform Act (MICRA) of 1975. For over 30 years, MICRA has demonstrated that medical liability costs can be stabilized while patients' rights are protected. This reform has had a demonstrated effect on malpractice insurance premiums. For example, premiums for a general surgeon in California averaged $41,775 in 2009, while in New Jersey, a state with no cap, they were $74,985.

The House of Representatives has considered and passed strong medical liability reform legislation modeled after successful state reforms on several occasions. One of the most essential elements of these bills has been a limit on non-economic damages to control the continually escalating severity of claims. This type of legislation has been estimated by the Congressional Budget Office to generate $54 billion in savings to the federal government alone, not to mention the savings to the nation's health system in general. A reasonable cap on non-economic damages would bring more economic stability to the medical liability system and still compensate individuals for pain and suffering.

American College of Surgeons
January 20, 2011

In addition to the cap on non-economic damages, the College advocates for the following policies for addressing the medical liability crisis and hopes that they will be included in strong medical liability reform legislation this Congress:

- Alternatives to civil litigation, such as health courts and early disclosure and compensation offers to encourage speedy resolution of claims.
- Protections for physicians who follow established evidence-based practice guidelines.
- Protections for physicians volunteering services in a disaster or local or national emergency situation.
- Collateral source payment offsets that prevent duplicate payments for the same expense.
- Fair share rule.
- Periodic payment of future damage awards over $50,000.
- Limits on plaintiff attorney contingency fees.
- Application of punitive damages only when there is clear and convincing evidence that the defendant intended to injure the claimant.

The College appreciates the Committee's interest in this issue and hopes that the House and the Senate will pass strong medical liability reform this year. The crisis confronting us continues to grow, and the impact is most severe on our sickest and most vulnerable patients.

The American College of Surgeons is a voluntary, educational and scientific organization of 77000 Fellows devoted to the ethical and competent practice of surgery and to enhancing the quality of care provided to surgical patients. Founded in 1913, the College was established to improve the care of surgical patients and the safety of the operating room environment. For over 90 years, the College has provided educational programs for its Fellows and for other surgeons in this country and throughout the world. In addition, the College establishes standards for the practice of surgical, trauma, and cancer care, as well as guidelines for office-based surgery facilities. It also provides information on surgical issues to the general public.

The College appreciates the opportunity to share our views on this vital issue. Questions and comments may be directed to the College's Washington Office, at 202-672-1500.

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American College of Surgeons
January 20, 2011

American Enterprise Institute for Public Policy Research

AEI

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Liability Outlook

Faulty Studies from Center for Justice & Democracy Are Stunting the Medical-Malpractice Debate

by Ted Frank and Martin F. Grace

Congress is scheduled to revisit medical-malpractice reform again this May. Americans for Insurance Reform (AIR), however, has announced that the medical liability crisis is "over," in an attempt to short-circuit the upcoming debate. This announcement is just the latest in a long line of faulty studies from AIR and its affiliate, the Center for Justice & Democracy (CJD), that have, unfortunately, insinuated themselves into and distorted the rational debate. To the extent one believes that the prices doctors pay for malpractice insurance present a crisis, the underlying causes of that crisis have not been addressed, even though rates are currently plateauing. While caps reduce insurance costs, medical liability reform will likely require more than caps in the long run, and medical-malpractice insurance rates could be adversely affected by other legal developments in insurance law.

CJD and its sibling organization Americans for Insurance Reform are anti–liability reform organizations that regularly issue manifestos masquerading as studies that blame insurers for the medical-malpractice crisis. Their accusations are frequently picked up by newswires, but months later someone looks at the actual study and finds that CJD cherry-picked or otherwise manipulated data to reach invalid conclusions. The refutations, however, never get the play of the original claims. As the Senate takes up medical-malpractice reform again in May, what is certain is that reform opponents will use CJD's misleading arguments in talking points. For example, the Association of Trial Lawyers of America highlighted a CJD study in an April 13 press release attacking President George W. Bush's call for malpractice reform.[1] The House Judiciary Committee Democratic staff's July 25, 2005, report attacking a malpractice bill passed by the House[2] relied heavily on CJD studies.[3]

CJD is hardly alone in slanting data. Too many organizations supporting malpractice reform exaggerate the growth of a very real problem by using nominal, rather than inflation-adjusted, data.[4] But the difference is one of degree. Even using constant dollars, medical-malpractice claims have grown approximately ten-fold over the last thirty years—with malpractice premiums tripling—and have potential adverse effects on access to care for the specialties worst affected.[5] However, the CJD studies positively misrepresent the state of the world. The result is that major media outlets such as the *New York Times* are questioning the uncontroversial proposition that damages caps reduce insurance costs[6] instead of focusing on legitimate questions: what can we do to create clear-cut standards for medicine to reduce error, and what can we do to make the litigation system less burdensome for good doctors?

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CJD's underlying theses—that malpractice insurance costs are rising because insurance companies are gouging their customers and that caps do not affect insurance prices—contradict basic economic principles. If there are excess profits being made by insurers, one would expect new entrants to rush in to take advantage of the opportunity and eventually compete away the surplus. In fact, we see the opposite: major insurers are deciding that they cannot make money offering medical-malpractice insurance and are leaving the market. In her 2002 testimony to Congress, CJD's Joanne Doroshow claimed that it was relevant that St. Paul Insurance left the medical-malpractice market around the same time it lost money investing in Enron.[7] This seems, at best, a non sequitur. Enron investment losses, even if significant, would not have caused St. Paul to abandon a moneymaking line of business. Furthermore, because of this significant market exit by a commercial insurer (as well as others that have taken place over the last thirty years), an even larger number of doctors obtain their malpractice insurance from physician-owned and operated nonprofit mutual insurance companies. We are being asked to believe that the doctors are overcharging themselves.

Similarly, if it were true that caps had no effect on insurance prices, insurers in states with caps would be missing a great market opportunity, as they could offer identically priced insurance and agree to waive caps. To the extent that patients prefer the opportunity to have unlimited damages when they sue their doctors, such cap-free insurance would quickly drive from the market any recalcitrant insurers that insisted on caps.[8] Even if one believed that existing insurers were too ossified in their beliefs to innovate in such a way, nothing prohibits the trial lawyers of America from pooling their billions in tobacco fees to form a new insurer to take advantage of this opportunity. (Recall that CJD is telling us that the insurer can make tremendous profits from doing so.) If CJD believes its own claims, it is making a serious judgment error in lobbying against insurance companies instead of raising money in the capital markets to compete against and replace them. Not only would the alleged gigantic insurer profits be siphoned from insurers to the new entity, but the new entity's very success would also be dispositive evidence against the efficacy of or need for liability reform.[9]

Major insurers are deciding that they cannot make money offering medical-malpractice insurance and are leaving the market.

So, right off the bat, something is fishy about CJD's conclusions. And sure enough, in recent years, time after time, CJD and its affiliate have had to cherry-pick doctor data and claims to reach those conclusions.

Once Is Happenstance: "Stable Losses"

AIR, a project of the CJD, released the third edition of its annual report, "Stable Losses/Unstable Rates 2004," in October of that year. The 2004 report, authored by Robert Hunter, argues that insurance prices are cyclical, and that the cycle exists because insurers took investment income and lowered prices to obtain market share. Then, when investment returns are low, the insurers increase rates and gouge the physicians.[10] This was a modulated version of the 2002 report, which claimed that stock market losses were responsible for the rate increases.[11] Apparently AIR had sufficient shame that it retreated from that claim once it was pointed out that 80 percent of medical-malpractice insurer investments are in bonds.

In an effort to make it appear that rates have declined over time, Hunter divides total insurance premiums by the number of doctors, then argues that the ratio has declined since 1975. In a footnote, he pays lip service to the idea that this ratio includes retired doctors and others who have no need of insurance, and waves it away by asserting that the percentage will stay the same over time.[12] But in an age of both increasing lifespans and early retirements, that is clearly not true. For example, the Bureau of Labor Statistics estimates that the number of working surgeons increased 6.5 percent between 1999 and 2002, while Hunter's number is a 9.7 percent increase in nonfederal doctors. Multiply this sort of dampening factor over the nearly thirty years of the study, and its figures will be off by more than a third.

Moreover, one cannot really look at premiums per physician as a meaningful figure. Not all doctors are in the same risk class. General practitioners, obstetricians, and neurosurgeons have distinct risks and distinct malpractice costs and cannot be so easily pooled.

Unfortunately for Hunter, his results are mystifying. His study inflated the denominator so much that it implausibly showed 2003 rates to be lower than the 1975–2003 average, implying that insurers should be raising rates even more.[13] Further, Hunter could not

massage the numbers enough to hide the increase in medical-malpractice losses. Even after using a medical-care inflation figure instead of the base consumer price index (which is arguably more appropriate, since medical-malpractice damages are not just related to medical expenditures) and using the wrong doctor-count denominator to dilute the results, Hunter's study still found that real losses per doctor had more than doubled between 1975 and 2003.[14] Further, the only reason the figure was that low was because the ratio for 1975 was unusually high and that for 2003 unusually low compared to the surrounding years. For example, the increase between 1976 and 2002 was 157 percent, thus showing how sensitive starting and ending dates were in this case.

There is some argument that investments have a minor impact on insurance rates: a study by the Government Accountability Office (GAO) concluded that a 1 percentage point increase in insurers' investment-return rates translates into the ability to lower premiums about 4.5 percentage points.[15] But medical-malpractice insurers' investments have been conservative (5.6 percent rate in 2000, 4 percent in 2002); the GAO translates this into a 7.2 percent difference in premiums, not the double- and triple-digit increases seen over the last few years. In the long run, medical-malpractice insurance prices reflect the costs of providing medical-malpractice insurance—and those, as the GAO found, have been steadily rising.

Twice Is Coincidence: The Angoff Report

There was no "Stable Rates/Unstable Losses 2005." Either the 2004 numbers ceased to support the methodology or CJD decided it needed a new methodology to grab press attention. If the latter, the ploy worked. In July 2005, CJD commissioned and released a report by Jay Angoff entitled, "Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry." The report's conclusion that "doctors have been price-gouged for several years as insurance industry profits have ballooned to unprecedented levels," received national publicity.[16]

This study, too, had to slice its data to reach these results.[17] First, it excluded from its research companies that had exited the market, such as St. Paul, PHICO, and Farmers Insurance. But malpractice insurers insure on a "claims-occurred" basis: if an event occurred some years in the past but is only recently discovered, the insurer covering the provider when the claim physically occurred is liable for the coverage. Thus, these companies that have exited the medical-liability business continue to incur billions of dollars of underwriting losses (unsupported by any additional premiums) even today, years after they have left the market. Add back into Angoff's study the omitted billion dollars or so these exiting companies had collected by 2001, as well as their underwriting losses, and CJD's conclusions of rapid premium increase and falling claims dissipate.

What is truly amazing about the report, however, is its absolute failure to consider expenses. Angoff looks only at claims paid and not the other expenses incurred in defending those claims. But defense lawyers are not free. If we include loss adjustment expenses (the expenses insurers pay to litigate and settle claims), we see that while the loss ratio including the expenses has decreased since 2000, it is still greater than one. Thus, on average, it costs $1.09 to close a case for each dollar of premium paid. This does not sound like the insurance industry is "profiteering," as Connecticut attorney general Richard Blumenthal accused in a CJD press release.[18] To be fair, this apparent loss turns into a profit when one includes investment returns; but still, the profit for 2004 was the first one in years. One year of profitability is hardly profiteering, but is rather a sign of health that will signal others to enter the industry, as is already happening in Texas after it enacted numerous tort reforms.[19]

Moreover, Angoff started his study in 2000, thus omitting the tremendous rise in the loss ratio that occurred in the 1990s. By expanding the scope of the Angoff inquiry in three dimensions—from a few years to the last fifteen, from fifteen surviving insurers to the entire industry, and from a subset of costs to the combined ratio of all costs and expenses to premiums—we get a different, and much more accurate, picture.

Medical-malpractice expenses rose sufficiently high that it took the giant premium increases of the early part of this decade to return the combined ratio to 1997 levels. And because these numbers exclude investment returns, one cannot blame Enron for the fluctuations.

The Angoff study examines insurer profitability, further slicing the data and cutting off the inquiry into surpluses and stock prices at 2002. Once again, as Jim Copland found, merely extending the scope of the study a few years dramatically changes the picture as the rise in stock prices between 2002 and 2005 only partially compensates for a tremendous drop between 1999 and

TABLE 1
MEDICAL MALPRACTICE COMBINED RATIO

Year	Percent
1990	106
1991	104
1992	128
1993	108
1994	96
1995	100
1996	107
1997	108
1998	116
1999	130
2000	134
2001	154
2002	141
2003	139
2004	109

SOURCES: AM Best Aggregates & Averages, 1990–2002; Insurance Information Institute, 2003–2004.

2002. A $3.4-billion industry-wide surplus in 2002 was down 15 percent from 1999.

Angoff's report also implies a sinister motive to the increase in surplus to the medical-malpractice carriers, as Angoff claims that each of the companies he looks at has capital that "exceeds the surplus the NAIC [National Association of Insurance Commissioners] deems as adequate."[20] The NAIC and the states have a risk-based capital (RBC) standard that requires the company to hold assets in reserve in accordance with the risk the companies face. Thus, companies writing riskier lines of business must hold more capital to ensure solvency. The NAIC designed RBC, in part, to focus regulators on the truly troubled companies and provide the regulators with authority to undertake specific remediation if the insurer's capital falls to such a level as to threaten the insurer's viability. RBC is a floor, not a ceiling; it was never suggested as an ideal or maximum amount of capital for an insurer to hold. When scrutinized, Angoff's accusation dissolves into a neutral factual statement that insurers (after substantial and necessary rate increases caused by increased loss ratios) have escaped insolvency. What is truly fascinating about Angoff's position is that he was the former insurance commissioner for the state of Missouri and would likely be extremely concerned if any or all the companies under his jurisdiction had only the minimum level of surplus required by the risk-based capital requirements. In fact, prudent managers will always attempt to have a number greater than the minimum. Therefore, Angoff's accusation is disingenuous at best.

The CJD report made the front page of the *New York Times* business section.[21] When the American Academy of Actuaries took the highly unusual step in October 2005 of criticizing the Angoff report as "incomplete, actuarially unsound, and misleading," the *Times* ignored the refutation.[22]

Three Times Is Enemy Action: The February 2006 AIR Report

CJD's Joanne Doroshow teamed with Robert J. Hunter to write "Insurance 'Crisis' Officially Over" in February 2006.[23] AIR calculated that medical-malpractice rates did not average any increase in 2004. (Never mind the 17 percent decrease in malpractice rates in Texas having something to do with that average rate. It is also worth noting that, without explanation for the difference, AIR changed its methodology for computing insurance rate increases since its 2004 report, suggesting cherry-picking.)

Amazingly, AIR concluded that a lack of increase or decrease proved that there was no longer any concern or crisis. Of course, if a doctor suggested to a patient who had doubled his cholesterol levels between 2000 and 2003 that the lack of movement in 2004 meant he was no longer at cardiovascular risk, he might be sued for malpractice. Readers can surely think of other examples. Imagine a hapless politician who suggests that unemployment is no longer a problem because, after years of increases, it has plateaued at 12 percent.

Worse, AIR got caught playing fast and loose with the data the same day they released the report. They claimed the Council of Insurance Agents & Brokers (CIAB) as a source, and CIAB acidly pointed out that AIR's claim of a 63 percent increase in fourth quarter 2002 rates actually came from a study showing that 63 percent of insurance accounts renewed that quarter had increased rates.[24]

Even beyond these painfully silly flaws, the report purported to show that caps had no effect on rate increases—with anecdotal evidence from a handful of states. Of course, looking at about five states with caps and about five states without caps is not a study. Ten data points make it nearly impossible to get statistical validation, and none is attempted. What is important is the relative size of the premium, the health of the market, and

whether other liability reforms are in place—not just whether the states had premium increases.

CIAB's rapid response perhaps deterred the mainstream media from acting as AIR's press agent for this study, as they had for the 2005 CJD study. Even the Association of Trial Laywers of America appears to have been sufficiently ashamed that it ignored the paper on the front page of its website. But the fact that the *Washington Monthly*'s "Political Animal" blog was quick to trumpet (and never retracted) the bogus numbers makes one worry that such false statistics will find their way into the legislative debate.[25]

As always, AIR takes the position that liability crisis is never caused by litigation, expansive judicial interpretation, or bad science. Instead, AIR would have us believe it is caused by mismanagement or greed by insurers. Or, as AIR alleges in this paper, it was caused by insurers that lowered premiums too much last decade because of mismanagement and now have to raise them. (Somehow, it is hard to imagine that Doroshow and Hunter would have contemporaneously applauded insurers that raised prices in the 1990s for their fiscal responsibility.)

"The Once and Future Crisis"

But now, according to AIR, the malpractice crisis will be over when the cycle is stabilized, arguing that the cycle is not caused by lawsuits, but by some external insurance market peculiarity. Therefore, AIR asks us to conclude that liability reform was a waste, as the insurance market will come back by itself. Again, this argument avoids the litigation and judicial-behavior side of the equation. It also avoids the state of the state malpractice insurance markets.

The problem with AIR's hypothesis is that an insurance cycle is not really a cycle at all, but rather a reaction to unpredictable shocks.[26] While we have had three shocks that correspond to the malpractice crises of the past, the industry has returned to some level of "profitability and stability" after the effects of the shock have worn off. The question that needs to be addressed is whether this a fragile stability or something more permanent.

University of Virginia Law professor Kenneth Abraham perhaps gives us the answer with a prescient 1991 paper titled, "The Once and Future Crisis."[27] Abraham predicted the current decade's crisis because the underlying problems of liability markets are only temporarily masked by the post-shock recovery. Abraham listed the reasons why a future crisis was inevitable in 1991; many of these reasons still apply today.

First, there is "tort cost push" because of increased frequency and severity of losses and increases in the largest, outlier awards. During the last crisis we saw a number of indicators of increased frequency and severity.[28] Anecdotally, we also saw a number of cases involving cerebral palsy due to alleged OB/GYN delivery room errors. And anecdotal evidence is relevant to these inquiries: it takes only a few outlier cases in a few states to raise OB premiums nationwide. Geoffrey Fieger has a multistate practice, and when he won a $17.5-million verdict in Pennsylvania in 2000, it was a data point that insurers in other states had to consider. Just the possibility that such a result could be replicated in another state is enough to increase the risk to an insurer of a lawsuit and raise premiums, even if there is no history of such a case happening in a particular state. This is more than just hypothetical. Fieger went on to win, among other cases against obstetricians and their hospitals, a $30-million verdict in Ohio and, just this March, a $17-million verdict in West Virginia. West Virginia has a non economic damages cap, but the end result in the Pochron family's lawsuit against obstetrician Louise E. Van Riper is to reduce the award to $13 million—prime demonstration that caps are only part of a reform effort and cannot carry the liability reform burden by themselves.[29]

> It takes only a few outlier cases in a few states to raise [obstetrics] premiums nationwide.

Of course, if there were a true relationship between cerebral palsy and delivery methods, physicians could learn safer techniques to deliver babies. Malpractice costs and birth defects would decrease and everyone would be better off. However, caesarian sections have quintupled without any decrease in cerebral palsy incidence.[30] All that is being added is costs to the system.

Second, there is increased legal uncertainty in the market. Legal uncertainty influences state markets in more ways than just higher or lower insurance prices. A major rationale behind liability reform is to reduce legal uncertainty. If one looks at common reform proposals such as damage caps, venue limitations, firm statutes of limitation, ending joint and several liability, or even restrictions on expert testimony, they tend to focus on reducing uncertainty. If we think about insurance pricing,

price is equal to the expected losses and expenses plus the cost of risk. We know that as the expected losses increase, the premiums go up, but as the cost of risk increases, premiums go up, too. Studies to date—even the more sophisticated academic ones that go beyond the single-variable models of CJD—simply have not addressed the importance of variance and extraterritorial effects.

Finally, Abraham discusses the potential problem caused by expansive judicial interpretations of insurance policies. Individuals only tangentially related to a risk may be responsible for the entire risk. Some of the liability reforms recently enacted go after this problem by reducing the effect of joint and several liability. But this particular problem does not necessarily have to be related directly to medical malpractice. For example, suppose judges in the Gulf states raked by Hurricane Katrina follow the demands of Mississippi attorney general Jim Hood and decide that homeowners' insurers are responsible for a specifically excluded loss, such as water damage. This decision will have an effect on homeowners' markets nationwide. But it will also affect all lines of insurance: insurers will perceive insurance contracts to have an increased risk of ex post judicial revision. Reinsurers will perceive this as a risk and therefore increase prices to compensate. Reinsurance costs will rise for all insurers no matter the line of business.

CJD and AIR believe that malpractice insurers are price gougers and deserve to lose money. However, consumer advocates did not complain when prices were being lowered, as they were in the mid-1990s. AIR forgets that insurance is a voluntary business based on risk assessment. It seems to believe that all regulators have to do is wave a magic wand and prices will become reasonable. Increased regulation, however, is not the answer. Stockholders require compensation for risk-taking, or they will not take the risk. However, insurers' prices are constrained by competition with the mutuals and risk retention groups, which act like nonprofits. In turn, it is hard to envision the managers of a nonprofit trying to raise insurance prices just so they can give back bigger dividends to their physician-owners. The nonprofits' motive is to make sure that they charge sufficient premiums to stay solvent rather than to extort premiums from their policyholders.

Liability reform has attempted to reduce uncertainty through limitations on losses or legal standards. One will not be able to determine until the next shock occurs how well the medical-malpractice insurance market has fared. But given the evidence from the past, one cannot conclude the crisis is over and that the markets are stable, much less that liability reform was or will be a waste.

We have new empirical evidence that doctors leave and enter markets in response to economic incentives.[31] Future studies may confirm or reject this common-sense hypothesis, but it is beyond question that insurers will actually leave markets when driven out by "consumer advocates" who only advocate for trial lawyers.

In many ways, the problem with AIR's reports is a perfect microcosm of what doctors find most distasteful about the liability system.

There is a legitimate debate to be had over the role of the liability system in promoting patient safety and injury compensation, a debate that has the potential to reduce health-care costs, improve health-care access, and ultimately save lives. Unfortunately, the debate is being sidetracked. In many ways, the problem with AIR's reports is a perfect microcosm of what doctors find most distasteful about the liability system: a trial-lawyer mentality that cherry-picks facts and twists data to reach knee-jerk conclusions under the guise of a false science. But how many times must CJD and AIR demonstrate that they either do not understand or will not apply basic principles of insurance markets and pricing before the media and politicians stop interjecting their seriously flawed conclusions into the discussion?

AEI research assistant Philip Wallach and AEI editorial assistant Nicole Passan worked with Mr. Frank and Dr. Grace to edit and produce this Liability Outlook.

Notes

1. American Trial Lawyers Association, "ATLA CEO Jon Haber's Statement in Response to Bush's Attacks Today on the Civil Justice System," news release, April 13, 2006, available at www.atla.org/pressroom/PressReleases/2006/april13.aspx (accessed April 19, 2006).

2. *Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2005*, HR 5, 109th Cong., *Congressional Record*, daily ed. (July 27, 2005): H 6860–69, available at www.govtrack.us/congress/bill.xpd?bill=h109-5 (accessed April 20, 2006).

3. U.S. House of Representatives, report of the House Judiciary Committee Democratic staff, *H.R. 5. Bad Medicine for American Consumers*, July 25, 2005, available at www.house.gov/judiciary_democrats/medmel109/staffrept72505.pdf (accessed April 20, 2006).

4. Bernard Black of the University of Texas made this point at an AEI conference, "Is There a Crisis in Medical Malpractice? New Evidence from Texas" (American Enterprise Institute, Washington, D.C., March 31, 2005), summary available at www.aei.org/event1037/ (accessed April 20, 2006).

5. Joseph B. Treaster and Joel Brinkley, "Behind Those Medical Malpractice Rates," *New York Times*, February 22, 2005, C2; for evidence of the adverse effects, see Jonathan Klick and Thomas Stratmann, "Medmal Reform and Physicians in High Risk Specialties" (working paper, American Enterprise Institute, Washington, D.C., March 21, 2006), available at www.aei.org/docLib/20060406_KlickMedmalReform.pdf (accessed April 20, 2006).

6. Compare Joseph B. Treaster and Joel Brinkley, "Behind Those Medical Malpractice Rates," with Tom Baker, *The Medical Malpractice Myth* (Chicago, Ill.: University of Chicago Press, 2005), 110–11. Baker, while opposing caps, acknowledges that they reduce insurance costs. For a scientific analysis supporting the general result that insurance costs are lower in states with caps, see also W. Kip Viscusi and Patricia H. Born., "Damages Caps, Insurability, and the Performance of Medical Malpractice Insurance," *Journal of Risk and Insurance* 72, no. 1 (2005): 23–43, abstract available at http://ssrn.com/abstract=669216 (accessed April 20, 2006).

7. House Subcommittee on Commercial and Administrative Law, Oversight Hearing on Health Care Litigation Reform, *Does Limitless Litigation Restrict Access to Health Care?* statement of Joanne Doroshow, executive director, Center for Justice & Democracy, June 12, 2002, available at www.centerjd.org/free/testimony.pdf, 10 (accessed April 20, 2006).

8. Of course, it is far from clear that consumers do prefer unlimited liability. When given the opportunity to opt out of noneconomic damages in exchange for lower auto insurance rates that reflect the savings from the option, about 90 percent of New Jersey drivers do so. See Stephanie Owings-Edwards, "Choice Automobile Insurance: The Experience of Kentucky, New Jersey, and Pennsylvania," *Journal of Insurance Regulation* 23, no. 1 (2004): 25–42.

9. This theme is further developed in Ted Frank, "Malpractice Myths," *Point of Law* (February 23, 2005), available at www.pointoflaw.com/columns/archives/000973.php (accessed April 19, 2006).

10. Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates 2004* (New York, N.Y.: Americans for Insurance Reform), October 2004, available at http://insurance-reform.org/StableLosses04.pdf (accessed April 20, 2006).

11. Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates* (New York, N.Y.: Americans for Insurance Reform), October 10, 2002, available at www.centerjd.org/air/StableLosses.pdf, 3 (accessed April 20, 2006).

12. Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates 2004*, n. 4.

13. Ibid., 5.

14. Ibid., 7.

15. Government Accountability Office, report to Congressional requesters, GAO-03-702, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Rate Premium Rates*, June 2003.

16. Jay Angoff, *Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry*, Center for Justice and Democracy (New York, N.Y.), July 2005, available at www.centerjd.org/ANOOFFReport.pdf (accessed April 20, 2006).

17. Jim Copland made many of these points first in "CJD's Med Mal Math," *Point of Law* (July 8, 2005), available at www.pointoflaw.com/archives/001292.php (accessed April 19, 2006).

18. Center for Justice & Democracy, "Two Leading State Attorneys General and State Insurance Commissioner Strongly Challenge the Insurance Industry's Price-Gouging of Doctors—Call for Oversight," news release, July 7, 2005, available at www.centerjd.org/press/release/050707.htm (accessed April 20, 2006).

19. See, for example, Travis E. Poling, "Lawsuit Limit May Be Just What the Doctors Ordered," *San Antonio Express-News*, February 26, 2006, A1.

20. Jay Angoff, *Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry*, 23.

21. Jenny Anderson, "Study Says Malpractice Payouts Aren't Rising," *New York Times*, July 7, 2005, C1.

22. American Academy of Actuaries, "American Academy of Actuaries' Medical Malpractice Subcommittee on the report by the Center for Justice & Democracy, *Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry*," news release, February 27, 2006, available at www.actuary.org/pdf/casualty/medmal_strm1005.pdf (accessed April 20, 2006).

23. Joanne Doroshow and Robert J. Hunter, *Insurance "Crisis" Officially Over* (New York, N.Y., Americans for Insurance Reform) February 27, 2006, available at www.insurance-reform.org/pr/MMSOFTMARKET.pdf (accessed April 20, 2006).

24. The Council of Insurance Agents and Brokers, "The Council Challenges AIR Conclusions on Med Mal," news release, February 27, 2006, available at www.ciab.com/Template.cfm?Section=News_Release2&CONTENTID=

4998&TEMPLATE=/ContentManagement/ContentDisplay.cfm (accessed April 20, 2006).

25. Kevin Drum, "No More Crisis . . ." Washington Monthly, Political Animal (weblog), February 27, 2006, available at www.washingtonmonthly.com/archives/individual/2006_02/008311.php (accessed April 20, 2006).

26. See, for example, Julie Cagle and Scott Harrington, "Insurance Supply with Capacity Constraints and Endogenous Insolvency Risk," *Journal of Risk and Uncertainty* 11, no. 3 (1999): 219–32.

27. Kenneth Abraham, "The Once and Future Crisis," *Journal of Risk and Uncertainty* 4, no. 4 (1991): 353–71.

28. Aon examined its claims and found that severity of medical malpractice claims has been growing at a nominal rate of 7.5 percent over the period 1995–2005, well over the rate of inflation in terms of the consumer price index growth rate (which has averaged approximately 2.8 percent per year, according to the Minneapolis Federal Reserve Bank, http://minneapolisfed.org/research/data/us/calc/). See Aon Corporation, 2005 *Hospital Professional Liability and Physician Liability Benchmark Analysis* (Chicago, Ill.: Aon, 2005).

29. Natalie Neysa Alund, "Jury Awards $17 Million in Lawsuit against Mon General Hospital: Child Suffered Brain Damage after Emergency Caesarean Section," *Dominion Post* (Morgantown, W.V.), March 29, 2006

30. Steven. L. Clark and Gary D. V. Hankins, "Temporal and Demographic Trends in Cerebral Palsy—Fact and Fiction," *American Journal of Obstetrics and Gynecology* 188, no. 3 (2003): 628–33.

31. Jonathan Klick and Thomas Stratmann, "Medmal Reform and Physicians in High Risk Specialties": Daniel P. Kessler, William M. Sage, and David J. Becker, "The Impact of Malpractice Reforms on the Supply of Physician Services," *Journal of the American Medical Association* 293, no. 21 (2005): 2618–25, abstract available at www.jama.ama-assn.org/cgi/content/short/293/21/2618 (accessed April 20, 2006).

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Submitted Statement of

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January 20, 2011

U.S. House of Representatives

Committee on the Judiciary

"Medical Liability Reform –

Cutting Costs, Spurring Investment, Creating Jobs"

The Physician Insurers Association of America (PIAA) commends Chairman Smith and the distinguished members of the Committee on the Judiciary for holding this hearing on medical professional liability (MPL) reform. Reform is not only a critical issue for our nation's healthcare system, as it has been for many years, but also a critical issue for our federal budget. It is imperative that it remain at the forefront of our attention for both reasons.

- **Doctors Insuring Doctors**
  The majority of doctors in the United States are insured by physician-owned and/or -operated insurers, whose primary mission is to provide access to dependable and affordable liability coverage.

The PIAA is a trade association whose 60 domestic medical professional liability (MPL) insurers collectively insure approximately 60% of America's practicing physicians, hundreds of hospitals, and thousands of other healthcare providers (including dentists, podiatrists, and numerous other specialties). Unlike the multi-line commercial carriers, MPL insurance is the primary focus of the PIAA companies. The PIAA is also unique in that its member companies are *owned and/or operated by the same physicians and other healthcare providers that they insure*. This gives us a dual perspective: of the MPL insurers and also of the healthcare providers our members insure. As such, the solutions sought by the PIAA are ones that serve the best interests of MPL insurers, healthcare providers, and their patients as well.

This fact highlights the gross mischaracterization of the industry that is frequently made by opponents of MPL reform. While the personal injury bar regularly repeats its accusation that increases in insurance premiums result from insurers' price-gouging, the physicians who are insured by these companies know that these arguments are patently false. In order to believe that insurers are overcharging for premiums, one must then believe that the physician-owners of these companies are intentionally choosing to overcharge *themselves*. This notion defies logic. Why would physicians who have the ability to set the price for a product that they also consume choose to make that product unnecessarily expensive? The answer is, that they wouldn't—and they don't. While the insurance cycle provides us with good years and bad years, overall, profits inure to the benefit of the policyholders.

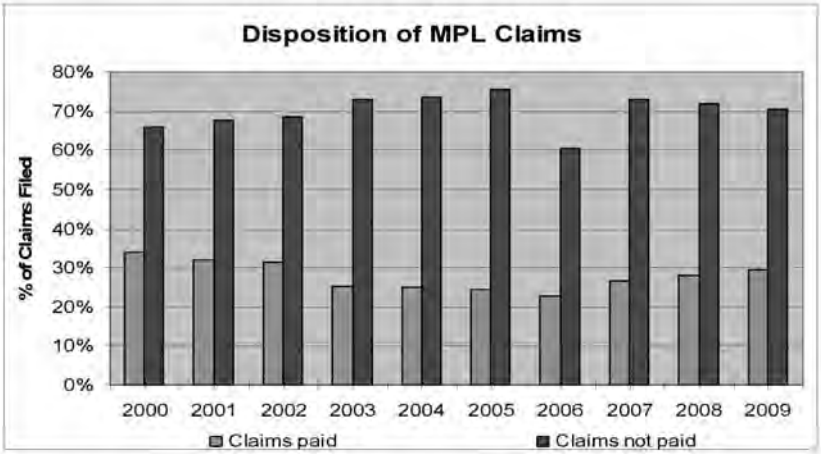
- **The Medical Liability System Is Broken**
  Neither doctors nor patients benefit from a system of rampant litigation. Only lawyers do, and thus they support a system that is fundamentally flawed and inefficient.

Our current system for assessing MPL is seriously flawed. Injured patients may wait more than four years on average for their claim to be resolved after an alleged injury. And then, when they are compensated, substantial sums of *their* money goes to pay attorney fees and other litigation expenses, thus depriving them of the funds that had been intended for their recovery. Unfortunately, no data exists, but, it is widely believed that 40% or more of awards and settlements is paid to the plaintiff attorney, who also passes along the costs of prosecuting the claim. At the same time, doctors may be needlessly dragged through lengthy litigation, their reputations tarnished even when it is proven that they did nothing amiss (which is the case more than 80% of the time for claims resolved at verdict). And personal injury lawyers? While

doctors, patients, and MPL insurers are seeking to fix the system, the personal injury bar, which stands to profit from it, steadfastly advocates for the status quo.

- **Most Medical Liability Claims Have No Merit**
  Every year, more than twice as many filed claims are proven to have no substance than are paid out. Nonetheless, the persisting accumulation of litigation needlessly clogs the courts and subjects healthcare providers to unnecessary stress and time away from caring for patients.

The overwhelming majority of claims that are filed against healthcare providers are demonstrated to have no merit and thus are dropped, withdrawn, or dismissed with no payment being made. According to the latest figures, over the last ten years, an average of 64% of all filed claims were dispensed in this manner. Even when a claim survives initial scrutiny, closer inspection still finds many that lack merit. Only 15% of claims which end in a jury verdict result in a verdict in favor of the plaintiff. The end result is that 70% of all claims filed are demonstrated to lack merit and result in no payment to the claimant.[1] (See chart.) These claims take a substantial toll on the physicians who are wrongly charged, in terms of emotional distress, loss of reputation, and time away from their practice.



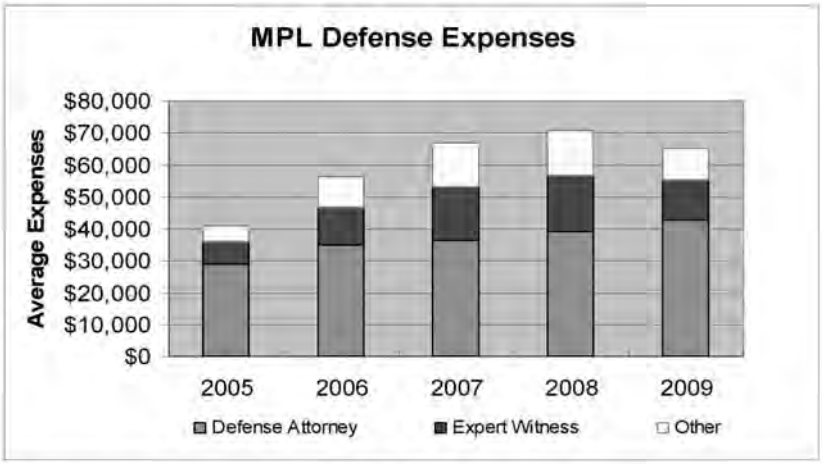
In addition, these meritless claims extract a significant financial toll on the MPL system. The average defense costs alone for a claim that is dropped, withdrawn, or dismissed total more than $26,000.[2] That's $26,000 for a claim that has been determined to have no merit. If a claim goes all the way to trial, it takes upwards of $140,000[3] to defend the doctor in those cases where the

[1] Physician Insurers Association of America 2010 Claim Trend Analysis, 6c.
[2] *Id.*, at 6b-4.
[3] *Id.*, at 6a-4.

jury eventually finds the claim to lack merit. These are funds which could have been used to pay a legitimate claim, support new patient safety initiatives, or provide a premium rebate. Instead, these healthcare dollars are simply squandered by a system that personal injury lawyers still maintain is effective.

- **Defense Costs Are Skyrocketing**
  MPL insurers must also contend with dramatically increasing costs to defend claims. These expenses are passed along to policyholders, thus increasing the costs for all doctors to do business, and increasing the overall cost of healthcare.

From 2005 to 2009, expert witness average expenses for a healthcare provider's defense increased by 78%, while defense attorney average fees increased by nearly 50%.[4] (See chart.) This is without factoring in whether or not a claim even has merit (costs for legitimate claims are substantially higher than those for meritless claims). These costs are then passed along to all healthcare providers in the form of higher MPL premiums. If something is not done to fix the MPL system, these costs will continue to rise.



- **Reforming the MPL System Will Help Patients**
  If MPL reforms are enacted, injured patients will be compensated more quickly and will receive a higher percentage of awards to cover their damages.

One claim made by the personal injury bar is that proponents of tort reform want to prevent severely injured patients from receiving compensation for their losses. In fact, nothing could be further from the truth. The PIAA has never advocated for capping total compensation to victims

[4] *Id.*, at 5b.

of medical negligence, and in fact, we recommend reforms that specifically allow for full compensation of a victim's total economic losses.

However, we do advocate specific monetary caps on damages for non-economic damages. Capping damages for pain and suffering, whose monetary value is obviously subjective and inherently immeasurable, in no way limits a victim's ability to be compensated for their actual economic losses. Lost wages, medical and rehabilitative expenses, in-home care services, etc., would still be fully compensated, as economic damages. A cap on non-economic damages brings a crucial measure of predictability to the MPL system. It lets patients and insurers evaluate the full extent of losses more quickly and accurately, and determine an arrangement for appropriate compensation. In addition, contrary to the trial bar's claims, caps on non-economic damages ensure that those with similar claims will be treated similarly throughout the MPL system— regardless of race, gender, age, or geographic location—thus ensuring equity in awards and settlements.

- **Tort Reform Will Put More Money in Patients' Hands**
  Personal injury lawyers retain a high percentage of the money that is intended to compensate victims of negligence. Restrictions on what attorneys could keep for themselves would help ensure that victims are fully compensated.

It is a common estimate that the contingency fee in an MPL claim is approximately 40% or more of the collected settlement or award. In addition, the attorney may also deduct expense costs, as well as additional litigation costs after assessing the contingency fee. So, a legitimate victim may receive as little as half of the settlement or award that had been determined as the requisite compensation for his or her loss. Unfortunately, we can only estimate this figure because, while everything is known about the defendant's costs due to state insurance regulations, nothing is actually known about the contingency fee practices of plaintiff attorneys except the little information gathered on an anecdotal basis. In any event, this system can hardly be called justice. A structured fee arrangement, calculated according to the amount of the award, will ensure that more money goes to the plaintiff when appropriate—not into the coffers of his/her lawyer.

- **Conclusion—the Status Quo Is Untenable**
  Our MPL system is broken. It does not work for the doctors it is supposed to oversee, nor does it serve the injured patients that it is intended to help. Doing nothing is not an option.

Mr. Chairman, to put it bluntly, the current system of medical professional liability is broken. The average claim takes more than four years to resolve, and more than 70% of claims filed are found to have no merit at all and result in no payment to the plaintiff. Of the claims that are resolved, it is estimated that 50% of an award or settlement that is supposed to compensate a victim for his/her losses actually goes to pay attorney fees and other litigation costs. Some consumer groups, not fully grasping all of the complexities of MPL coverage and patient compensation, join the trial bar in advocating for the status quo. However, as the PIAA has explained herein, it is time for a change—and by this we do not mean tinkering around the edges, or demonstration projects, but real change, based on the demonstrable successes states such as California and Texas have achieved in overhauling the MPL systems.

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