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**Testimony of Jillian Aldebron
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Before the Committee on the Judiciary
Hearing on B16-283, "Health Care Reform Act of 2005"
and B16-418, "Medical Malpractice Reform Act of 2005"
December 1, 2005**

Chairman Mendelson and Members of the Committee,

Thank you for allowing me to testify today on behalf of Public Citizen's 800 members in the District and, in fact, for the benefit of all consumers of healthcare services in Washington, D.C. Those who seek medical treatment here need to be assured that the District, in its laws and regulations, stands behind the quality of the services provided by its healthcare licensees. After all, the legal structure is meant to serve as a source of justice for the injured, accountability for wrongdoers, and protection for the public at large.

The draconian restrictions of medical malpractice law proposed by Mayor Williams in Bill 16-283, however, send a very different message. They say: buyer beware, even of the professionals who bear our seal of approval, because you will have little recourse if something goes wrong. It undermines the basic principles of justice, fairness and personal responsibility upon which society is premised and that District residents depend on their government to preserve.

The Mayor's proposal is unjust on its face. Why? Because it shifts the burden of paying for the consequences of negligent medical care from the wrongdoers to both victims and taxpayers. It sets no limit on how badly a patient can be hurt, but puts a ceiling on how much a patient or a deceased patient's family can be compensated for what are often life-altering injuries. It makes taxpayers foot part of the bill for a bad doctor's negligence when Medicare, Medicaid, workers compensation or social security disability are available, letting perpetrators off the hook cheap instead of paying their fair share. It makes it even harder for victims to get into court, and harder for them to prevail when they do—although as the law now stands, medical malpractice cases are by their nature so difficult to prove that just 30 percent of plaintiffs succeed at trial and only 50 percent of claimants get settlement payments.¹

Special interest groups claim that capping non-economic damages, changing collateral source rules, instituting periodic payments, and requiring certificates of merit stop so-called "frivolous

¹ Neil Vidmar *et al.*, "Medical Malpractice Lawsuits: An Essay on Patient Interests, the Contingency Fee System, Juries and Social Policy," *Loyola Los Angeles Law Review* 38:1217-1266 (2005).

lawsuits.” There is no logic to this argument. Frivolous lawsuits are not stopped at the payment end where caps and other compensation-related changes kick in: they are stopped at the front end of the tort system. Frivolous lawsuits are short-circuited by judges who dismiss cases without merit, by insurers who won’t settle baseless claims for fear of destroying their credibility, and by plaintiffs attorneys who refuse to throw away as much as \$200,000 in up-front costs to mount a medical malpractice lawsuit they have no chance of winning because it is groundless.

Studies indicate that plaintiffs’ attorneys already reject over 90 percent of potential clients with medical malpractice cases, frivolous and meritorious alike, because the costs of bringing the suits are so high and the chances of winning so slim.² Frivolous claimants should not have damages capped—they should, and do, get nothing at all. The Mayor’s proposal doesn’t address frivolous claims. Instead, it attacks the victims of negligent doctors who prevail in court, the ones whose futures are bound to wheelchairs, whose ambitions must be shrunk to fit their broken bodies, or whose dreams for their children remain forever frozen in time because a medical practitioner failed to apply the standard of care that a reasonable doctor would have used. Those are the people whose pain and suffering the Mayor has valued at \$250,000, doled out in actuarially-calculated installments.

Special interest groups claim that cutting back on patients’ legal rights will reduce the cost of malpractice insurance premiums and keep doctors in the District. This claim is utterly baseless. First, no malpractice insurer has promised to reduce rates once patients’ legal rights are taken away. In fact, insurers and reinsurers have steadfastly avoided making any commitment to rate reductions under a modified legal regime. Moreover, even if they had, that would still beg the question of whether it is morally defensible—or sensible from a public policy standpoint—to shift the cost of bad medical treatment from the doctors responsible to innocent victims and taxpayers.

Second, the claim is premised on the notion that doctors are abandoning the District because of high malpractice insurance premiums and jeopardizing the availability of medical care. This, too, is patently false. The American Medical Association ranks the District as No. 1 in the country for the number of practicing physicians per resident: at 6.0 doctors per 1,000 residents it has nearly double the concentration of the next best state, and more than twice the national average of 2.3.³ The number of licensed physicians per 1,000 District residents has risen 51.9 percent over the past decade—despite periodic malpractice insurance rate spikes—according to a Public Citizen analysis of Federation of State Medical Board data.

High insurance premiums, which do not correlate with the number of malpractice incidents, may cause some doctors at the margins to retire early or initially set up practice elsewhere, but the effect is clearly minimal and insufficient to endanger access to health care for District residents. Incidentally, the state with the second greatest concentration of practicing physicians per capita, Massachusetts, has minimal restrictions on malpractice lawsuits and no damage caps.

² Herbert Kritzer, “Risks, Reputations and Rewards: Contingency Fee Legal Practice in the United States,” Stanford Law and Politics, 2004.

³ Physician Characteristics and Distribution in the U.S., 2005 Edition. The District has 6.0 physicians per 1,000 population, compared to the

Lastly, there is the contention that medical malpractice claims are responsible for driving up the cost of health care. According to the Congressional Budget Office, medical malpractice costs account for less than 2 percent of total health care spending.⁴ A pittance. On the other hand, extrapolating from Institute of Medicine data, preventable medical errors cost the District an estimated \$59 million a year for hospital in-patients alone.⁵ Nationwide, medical injuries during hospitalization add 2.4 million days to hospital stays, according to a review of patient discharge abstracts from 994 acute-care hospitals in 28 states.⁶ Clearly, there is one surefire way to increase the availability of healthcare in the District and elsewhere, if that is the goal: reduce the incidence of medical negligence that is diverting resources away from first line treatment to remediating injuries caused by substandard care.

In 1999, the Institute of Medicine set off a firestorm when it announced that avoidable medical errors were killing as many as 98,000 hospital patients a year in the U.S. Subsequent research indicates that this estimate was, in fact, overly conservative. A 2003 survey of patients in 12 metropolitan areas throughout the country found that adults seeking preventive, chronic or acute care had just over a 50 percent chance of getting treatment that met the recommended standard.⁷ The most recent data indicate that 1 in 20 hospital patients is given the wrong medication, 3.5 million are given infections due to unhygienic or improper procedures, and 195,000 die because of avoidable mistakes.⁸ That the incidence of medical errors is so high is no surprise to doctors. In a 2002 survey of physicians and the public, 35 percent of doctors reported that they themselves had been on the receiving end of medical errors in their own healthcare, and that half the time this had resulted in serious consequences; nearly one-third of doctors surveyed reported witnessing medical errors in their professional capacities.⁹

What most laypersons find surprising but is hardly a secret in the medical and legal research communities is that just a fraction of those hurt by negligent doctors ever seek compensation for their injuries. Studies show that roughly only 1 in 10 victims of medical negligence pursue claims against the offending physician.¹⁰ The vast disparity between the incidence of medical negligence and the incidence of negligence claims has led Prof. Tom Baker of the University of Connecticut, a leading expert on insurance law, to conclude that the U.S. is suffering from “an epidemic of medical malpractice, not malpractice lawsuits.”¹¹

These facts suggest that the Mayor’s approach to the crisis of medical negligence is focused 180 degrees in the wrong direction. The Council should be considering how to improve the quality of healthcare, enforce accountability for misconduct, and ensure that more injured patients are

⁴ “Limiting Tort Liability for Medical Malpractice,” Congressional Budget Office, Economic and Budget Issue Brief, January 2004.

⁵ *To Err is Human*, Institute of Medicine, 1999.

⁶ Chunliu Zhan, *et al.*, *Excess length of stay, charges, and mortality attributable to medical injuries during hospitalization*, JAMA, 290:1868, 2003.

⁷ Elizabeth A. McGlynn, *et al.*, *The Quality of Health Care Delivered to Adults in the United States*, New England Journal of Medicine, 348:36, June 2003.

⁸ David Maxfield, *et al.*, *Silence Kills: The Seven Crucial Conversations for Healthcare*, VitalSmarts, 2005.

⁹ Robert J. Blendon, *et al.*, *Views of practicing physicians and the public on medical errors*, New England Journal of Medicine, 347:1933-40 (2002).

¹⁰ Randall Bovbjerg *et al.*, *Surmounting Myths and Mindsets in Medical Malpractice*, The Urban Institute, Health Policy Brief, October 2005.

¹¹ Tom Baker, *The Medical Malpractice Myth*, University of Chicago Press, 2005.

compensated by those who hurt them rather than by taxpayers. Fortunately, Councilmember Catania has introduced legislation now pending before the Health Committee that will lead to stricter doctor discipline and increasing patient safety.

The Mayor's proposed legal restrictions, however, will only create additional—if not insuperable—hurdles to justice for those who are harmed, leave doctors without the insurance relief they demand, and weaken the medical establishment's incentive to improve patient safety. They will reduce only the *appearance* of medical negligence, driving it from the public view of courtrooms and front page headlines by keeping victims out of court and keeping costs to doctors and insurers down. The reality of dangerous, risky, substandard medical care will persist, however, only its corrosive effects will be further disbursed among taxpayers through increased pressure on public benefits and heightened social stressors. As Prof. Baker points out in his recent book, some 20 years ago lawsuits and the high cost of malpractice insurance drove anesthesiologists to learn from the negligence claims against their colleagues and implement best practices that have resulted in dramatically reduced incidents of anesthesiology injuries and equally dramatic reductions and stability in anesthesiologists' malpractice insurance rates.

I would like to focus more specifically on the Mayor's proposal to demonstrate how his approach denies victims justice and jeopardizes public welfare.

A \$250,000 cap on non-economic damages is discriminatory and inhumane.

The *sine qua non* of the tort “reform” lobby, and the centerpiece of the Mayor's bill, is the \$250,000 cap on non-economic damages in a suit against a negligent physician. Non-economic damages compensate victims for physical pain, mental anguish, sexual dysfunction, infertility, loss of parental guidance and other hard-to-quantify consequences of enduring catastrophic injuries or death. Typically, non-economic damages exceed \$250,000 only in cases involving permanent, significant injuries. Thus, as a Harvard team studying the impact of California's \$250,000 non-economic damage cap confirmed, caps discriminate against those who suffer the greatest harm.¹² Moreover, the Harvard study found that because the most severely injured victims tended to be under-compensated for their economic losses even before the cap kicked in, imposing a ceiling on non-economic damages further exacerbated the insufficiency of their financial recovery.

But regardless of the degree of affliction or indignity to which an individual has been consigned, caps unfairly disadvantage those with little, if any, economic damages, especially women, infants, the elderly, and low-wage earners.¹³ Elderly plaintiffs often have no lost earning potential, so their economic damages largely consist of medical expenses. Women who suffer sexual and reproductive injuries that radically impair their sense of identity, self-esteem, and social relationships but do not require continuing medical care or stop them from working also have minimal economic losses. Without the availability of non-economic damages, neither these victims nor their families would be compensated for the injuries inflicted by negligent doctors. Worse still, the potential recovery for such victims is so reduced that it deprives plaintiff

¹² David Studdert, *et al.*, *Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California*, Health Affairs, 21:54 (2004)

¹³ Lucinda Finley, *The Hidden Victims of Tort Reform*, Emory Law Journal 53:1263 (2004)

attorneys of a reasonable return on their own financial investment in a case. And here is the real motivation driving the tort “reform” lobby’s push for caps—they deprive victims of medical negligence of the ability to hire legal assistance to pursue their claims. No lawyer, no lawsuit. Studies on the effects of non-economic damage caps have shown that they reduce the number of malpractice claims.¹⁴

The Mayor has proposed a \$250,000 non-economic damage cap for physician negligence that is forever frozen in time. In 1975 when California adopted such a cap, the amount corresponded with the high end of non-economic damage awards in malpractice cases in that state. Since then, its value has eroded dramatically, and will continue to do so.

How much is \$250,000—which is now an entirely arbitrary figure—worth to a victim?

- For someone injured at age 25 who lives to the average life expectancy of 77.6 years,¹⁵ \$250,000 equals just \$13 per day.

How much is \$250,000 worth to a defendant?

- Six weeks’ pay for A. Derrill Crowe, the president and chief executive officer of ProAssurance Corp., the District’s leading medical malpractice insurer.¹⁶
- Comparable to the \$255,000 average annual income of obstetrician/gynecologists, who claim to be among the doctors hardest hit by the malpractice insurance “crisis.”¹⁷

Giving defendants offsets for collateral source benefits lets them escape full responsibility for wrongdoing and shifts the costs to others.

“Collateral source benefits” are payments made by third parties, usually insurers or employers, to compensate the victim for medical expenses and lost income. These may include life, health and disability insurance, as well as government entitlements such as Medicaid, Medicare, Social Security disability and workers’ compensation. A long-held principle of tort law known as the “collateral source rule” bars defendants from introducing evidence that a plaintiff will recover collateral source benefits. The purpose of the rule is twofold: It ensures that defendants are held fully accountable for their misconduct. It ensures that defendants cannot pass compensation costs to another entity, such as a plaintiff’s health insurance company. This does not mean that plaintiffs get paid twice for the same loss. In cases where plaintiffs can recover from both defendants and third parties, they must reimburse the insurer—who often is bound by law to demand repayment.¹⁸ In some cases, there is a right of subrogation, where the insurer intervenes directly in prosecution of the lawsuit on the plaintiff’s behalf. Thus, the plaintiff only gets to keep compensation for actual damages.

¹⁴ See, e.g., Daniel P. Kessler, *et al.*, *How Liability Law Affects Medical Productivity*, Working Paper No. 7533, National Bureau of Economic Research, February 2000.

¹⁵ See <http://www.cdc.gov/nchs/fastats/lifexpec.htm>.

¹⁶ ProAssurance Corp. proxy statement filed with Securities and Exchange Commission April 18, 2005.

¹⁷ Modern Healthcare magazine, *Holding Steady*, July 18, 2005.

¹⁸ In the case of government benefits, recovery is mandated by the Medical Care Recovery Act (*see* 42 U.S.C. §2651(a)).

The Mayor's proposal would turn this rule on its head, not only allowing evidence of collateral source benefits to be heard, but reducing the defendant's liability by the portion of damages paid by a third party insurer. This means that:

- Taxpayers will be subsidizing medical negligence when a victim's medical expenses are compensated by the government, while the defendant who caused the injury will get off cheap. Health insurance policy holders will be subsidizing wrongdoers when plaintiffs are covered by private insurance, feeling the hit in premium increases.
- Wrongdoers will escape responsibility for their actions.
- Medical practitioners will have less of an incentive to act responsibly or take greater precautions against medical errors because the penalty will not be as severe.
- Victims whose third party payer is the government, as in the case of Medicare recipients, risk reductions of future medical services in the event of funding cut backs.
- Victims with private insurance *lose money* because they have paid and will continue to pay premiums for coverage under these policies.

The Mayor's proposal does not save money. It simply shifts the costs from one party to another and creates added vulnerabilities for injured patients and their families. This is government policy at its worst—protecting wrongdoers at the expense of victims and the public at large.

Parceling out payments to victims over many years deprives them of fair compensation and rewards defendants with a windfall.

A plaintiff who prevails in a medical malpractice claim is traditionally compensated with a lump sum payment that covers both past and future losses. The Mayor's proposal, however, changes this by allowing "periodic payments" for future damages over \$50,000, with no guidelines or restrictions on how those periodic payments are calculated or requirement that the payments be converted to present value. This means that instead of negligent physicians and their insurers paying up front, they can string out payments over the life expectancy of the victim—reaping a significant windfall because an award apportioned over many years progressively decreases in value due to inflation (witness the value of the \$250,000 cap in 1975 compared to today, 30 years later). Meanwhile, they get to invest and earn interest on money that is otherwise due to an injured patient. Defendants and their insurers save still more money if the plaintiff dies prior to expiration of the payment term, in which case the defendant's responsibility for some portion of the remainder terminates.

Victims, on the other hand, would be short-changed, cheated of the compensation they need and deserve. Moreover, because periodic payment arrangements are impossible to modify, victims are placed in a straight jacket, unable to deviate from the pre-determined schedule even for emergencies. If the cost of medical care increases beyond the amount allowed in the schedule, or a special expensive medical technology becomes available that plaintiffs require—or that could measurably improve the quality of their lives—plaintiffs do not have the flexibility to adjust the payments to meet those changing needs.

A cap on plaintiffs' attorney fees creates an additional barrier for victims seeking legal representation.

Malpractice attorneys represent plaintiffs on a contingency fee basis: they invest their own money and resources to cover expert witness fees, discovery costs and other litigation expenses up front in return for a percentage of the damage award, typically one-third, if their clients prevail. This arrangement benefits plaintiffs who cannot afford either to advance money nor hire an attorney on an hourly basis; it enables even the poorest victims to obtain high quality legal representation. The prospect of a substantial payout if they succeed gives attorneys an incentive to assume the significant risk of financing medical malpractice lawsuits, whose complexity makes them notoriously expensive to pursue and difficult to win.

The Mayor's proposal would undermine this system by strictly limiting the percentage of a damage award that plaintiffs can pay to their own attorneys. The bill's limit on attorney fees is so restrictive that it will discourage plaintiffs' attorneys from taking any but the most potentially lucrative cases: those involving higher-income victims who have suffered severe permanent injury or death. Low-income plaintiffs will be unable to find attorneys to pursue their otherwise meritorious claims in court.

Defendants, on the other hand, will not be similarly burdened: the Mayor would give defendants free rein to pay their attorneys as much as they like, tilting still further the scales of justice already weighted in favor of resource-rich defendants. The only argument for capping plaintiffs' attorneys fees is to lower the legal costs for both the plaintiff and the defendant. Defense attorney fees, however, add to the legal cost in precisely the same way that plaintiffs do. Thus, if the goal is to limit legal costs and thereby maximize the money that is available for the plaintiff (and limit needless expenditures by the defendant), caps on both sides are the only defensible way to go.

The bottom line: capping only the plaintiff's fees while leaving a "sky is the limit" blank check for the defendant's fees, inevitably leads to a skewed playing field where the defendant can always bring superior legal resources against the plaintiff.

Punitive damages would *rarely* be awarded and would be capped.

Punitive damages are awarded to punish particularly egregious behavior. Although they are granted in fewer than one percent of all medical malpractice cases, their availability is an important incentive to physicians, hospitals, HMOs, nursing homes and drug and medical device manufacturers to put patient safety first. But the Mayor's bill would impose extensive practice and procedural changes that will make it much more difficult to plead and prove punitive damages in all healthcare lawsuits.

The Mayor wants to heighten the standard of culpability required for awarding punitive damages from the current "recklessness" to intentional harm. Recklessness is behavior that the actor knows or should know is likely to cause harm because it constitutes a gross deviation from the standard of care a reasonable person would exercise in like circumstances. When a doctor fails to make sure he is operating on the correct organ and as a result erroneously removes a healthy

instead of a diseased lung, leaving the patient permanently and severely disabled, that is recklessness. When a blood bank fails to follow standards for donor screening and blood testing, and so infects a patient (who in turn infects his wife) with HIV, that is recklessness. The rationale for assessing punitive damages in these real-life examples is both to punish the flagrantly negligent perpetrator and to discourage similar conduct by others in the future. Changing the standard for awarding punitive damages to “malicious intent to injure,” as the Mayor proposes, means that cases of recklessness such as these would go unpunished. Instead, only a medical practitioner who deliberately injured or tried to injure a patient, or who was substantially certain that injury would occur as a consequence of his or her act would pay punitive damages.

In addition, the defendant’s intent must be proved by “clear and convincing evidence,” a level of proof beyond the current standard of preponderance of the evidence and one that approaches the standard for criminal convictions.

The Mayor’s proposal also would bar claimants from asking for punitive damages at the outset of a lawsuit. First they would have to convince the judge that they were substantially likely to prevail on their punitive damage claim, and only then would they be allowed—at the judge’s discretion—to make their case before a jury. This new double hurdle would increase court costs and attorney fees both for plaintiff and defendant, and further delay the resolution of a claim. And prescribing healthcare providers would be immunized from liability in a product liability case so long as the drug they administered or medical device they used (including blood products) was approved by the Federal Drug Administration (FDA). And, in the rare instances that punitive damages could be awarded under this onerous regime, they would be limited to \$500,000, or twice the economic damages—whichever is greater.

Most disturbingly, the Mayor gives a special punitive damage shield to drug companies and medical device manufacturers! His proposal prohibits punitive damages against drug companies and manufacturers of medical devices for injuries caused by FDA-approved products, or those recognized by qualified experts as safe and effective pursuant to guidelines established by the FDA. The only exception to this rule is if the victim can show by *clear and convincing evidence* that the defendant knowingly bribed, misrepresented to or withheld from the FDA material information related to the resulting harm. Lawsuits brought for mislabeling or defective tamper-resistant packaging would be entirely barred by the Mayor’s proposal, unless there is clear and convincing evidence that the labeling and packaging is substantially out of compliance with regulations promulgated by the Secretary of Health and Human Services.

Given that the professed rationale for the tort law changes proposed by the Mayor is to lower medical malpractice insurance premiums for doctors, it is hard to justify the including special liability exemptions for the drug industry in the Mayor’s bill. This is particularly disturbing in light of recent high-profile cases in which patients who took FDA-approved drugs such as Vioxx and Rezulin sustained serious adverse effects and even death. Exempting drug makers from punitive damages would increase the risk of injuries from dangerous or defective products by removing the financial deterrent to reckless conduct.

Finally, I would like to take this opportunity to comment on the scare tactics of the D.C. Medical Society, which is warning residents that they are facing drastic cuts in access to medical care because doctors are being driven out of the District by high malpractice insurance premiums.

One claim in particular turns up over and over again—in fact it was asserted just 10 days ago in this same Chamber before the Health Committee by then president of the Medical Society, Victor Freeman—that obstetricians are fleeing the District, leaving women unable to find anyone to deliver their babies. The MSDC website, in fact, states that “...the 2005 Washington Physicians Directory lists 151 OB/GYNs. Earlier this year, MSDC surveyed 141 of the OB/GYNs listed and found that more than 40 percent had stopped delivering babies in DC.”

Public Citizen decided to investigate the truth behind this claim. We took the Washington Physicians Directory, which incidentally lists 137—not 151—OB/GYNs in the District, and telephoned each and every one of them. What we found was that when you exclude the non-working numbers, retired doctors, those in gynecological specialties, there remain just 19 OB/GYNs—or 17 percent of the total—who exclusively practice gynecology and do not deliver babies. That is, 17 percent versus the 40 percent claim made by Dr. Freeman. Moreover, this says nothing about how many of these 19 gynecologists either discontinued their OB practice, or *never* delivered babies in the first place.

I have appended to my testimony the full report on our survey of practicing obstetricians in the District, which explains our methodology in detail and has a complete listing by name of every obstetrician currently accepting patients in the District. When we used all available listings and sources for District OB/GYNs—not just the Washington Physicians Directory—we found a total of 113 practicing obstetricians, of whom 96 percent were currently taking new patients. This does not include the 92 OB/GYN residents who deliver babies at four major D.C. hospitals, and at least 18 nurse midwives.

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