

**Statement of Public Citizen
Before the
Governor's Select Task Force on Healthcare
Professional Liability Insurance
October 21, 2002
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Highlights of Public Citizen's Statement Before the Governor's Select Task Force on Healthcare Professional Liability Insurance

1. Rather than facing “runaway litigation,” doctors benefit from a medical malpractice claims gap

Only a small percentage of medical errors result in lawsuits. Twelve years ago, Harvard researchers using a sample of hospitalizations in New York State found that only one in eight medical errors in hospitals results in a malpractice claim. According to Florida's Agency for Health Care Administration, from 1996 through 1999, Florida hospitals reported 19,885 adverse incidents but only 3,177 medical malpractice claims. In other words, for every 6 medical errors only 1 claim is filed. Among the errors reported in 2001 were: 9 incidents of surgery performed on the wrong patient; 16 incidents where the wrong procedure was performed; 54 incidents where the procedure was performed on the wrong site; and 122 incidents where a foreign object was left in a patient after surgery.

Because so few medical injuries result in compensation to patients, the overall expenditures made for medical liability are far below the projected injury costs. The Institute of Medicine estimated the costs of preventable medical injuries at between \$17 billion and \$29 billion. The Utah-Colorado Medical Practice study estimated it at \$20 billion. By contrast, the National Association of Insurance Commissioners reports that the total amount spent on medical malpractice insurance in 2000 was \$6.4 billion.

2. Empirical evidence does not confirm the existence of “defensive medicine”

Medical providers say that they often take unnecessary precautions, such as ordering unneeded tests, to avoid potential liability. But while a search of the scholarly literature on medicine will turn up dozens of studies documenting the incidence of medical errors, there isn't one peer-reviewed study documenting the incidence of purely defensive medicine. The theory of defensive medicine can't account for such recent shocking findings by patient safety researchers as:

- An Auburn University study of 36 hospitals and nursing homes in Colorado and Georgia that found that on average, 19 percent of medication doses were given in error, with 7 percent judged to be potentially harmful.
- A case study finding that medical personnel had ignored “many seemingly clear signals that they were subjecting the wrong patient to an invasive procedure,” in which such “defensive medicine” measures *not* performed included follow-up questioning or record-checking after the patient told personnel she had not been admitted for cardiac treatment.

3. Increases in awards to plaintiffs result from demographic and inflationary trends in society at large, not irrational juries

Dr. Richard Anderson of The Doctors Company has complained that “since 1990, [malpractice] claims costs have risen annually by 6.9 percent, nearly three times the rate of inflation.” But Bureau of Labor Statistics data indicates that medical care services, usually the largest element of a damages award, have had 6.18 percent annual growth, and hospital and related services have

had an 8.28 percent annual growth rate. Increased life expectancy and a higher retirement age have also driven up the dollar costs of injuries. Spikes in insurance premiums have resulted from investment losses and artificially low rates in the 1990s designed to increase cash flow. These market problems have affected many types of insurance products. In Florida, health insurance prices increased by 20 to 28 percent in 2002 while some homeowners lines increased more than 15 percent. Malpractice insurance rates increased in Florida by an average of 26 percent in 2001-2002, comparable to other types of insurance.

4. Much of the high costs of medical malpractice insurance may be attributable to hardball litigation tactics demanded by doctors themselves

Malpractice lawsuit defense costs are far higher than litigation costs in other lines of insurance, and insurers use this willingness to fight hard as a selling point in marketing their policies to doctors. The average medical malpractice insurer spends 32 percent of premiums on defense costs; one actually spends 49 percent of its premiums on defense costs. By contrast, the corresponding figures are 4.8 percent for passenger auto liability, 7.1 percent for commercial auto liability, and 16.5 percent for commercial general liability. Medical negligence insurers should explain why their defense expenditures exceed even those for product liability cases (28.9 percent), despite the fact that product cases involve more defense attorneys and more expert witnesses.

5. The insurance industry's own numbers indicate that plaintiffs and their attorneys are not pursuing frivolous cases

The Physician Insurers Association of America reports that 63 percent of all malpractice claims are "dropped, withdrawn or dismissed." In other words, in most malpractice cases patients are deciding after investigation that a claim should not be pursued and dropping it voluntarily. The number of cases withdrawn voluntarily by plaintiffs is *ten times* the number of cases that are taken to trial and lost. The percentage of claims pursued by plaintiffs to final rejection by a jury is only *five percent*.

6. Florida should strengthen oversight of the medical profession to reduce injury costs

A small number of doctors commit most of the medical negligence in Florida. According to Public Citizen's analysis of the public use file of the National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, only six percent, or 2,674 of Florida's 44,747 doctors, have paid two or more malpractice awards to patients. These doctors are responsible for 51 percent of all payments and 47 percent of the dollar-value payments. They have paid out \$1.2 billion in damages.

The two percent of Florida's doctors who have made three or more malpractice payments account for 22 percent of all malpractice. The Florida Board of Medicine is dangerously lenient with doctors, repeatedly letting serious and sometimes repeat offenders off the hook. In Public Citizen's ranking of state medical boards, Florida ranked 26th in vigilance.

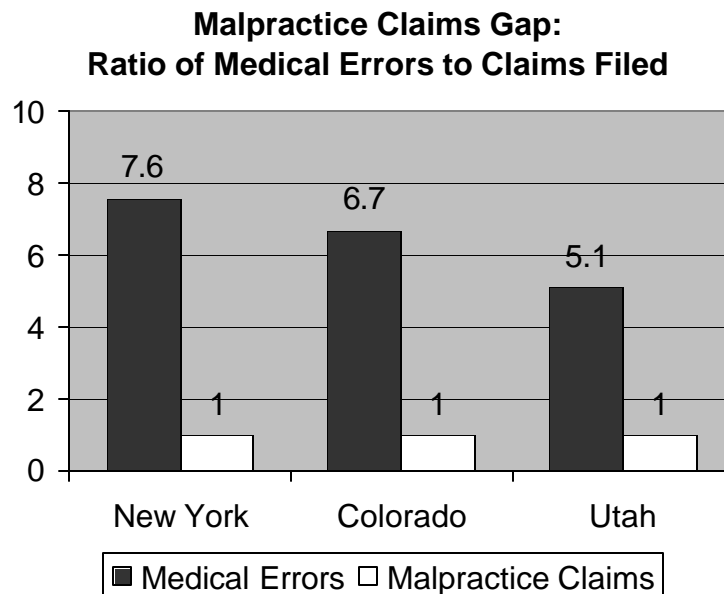
I. Rather than Facing “Runaway Litigation,” Doctors Benefit From a Medical Malpractice Claims Gap

Is the number of medical malpractice lawsuits “excessive”? Doctors contend that many medical malpractice claims are “frivolous.” They argue that the civil justice system is unable to tell frivolous from meritorious claims, erring on the side of paying compensation to plaintiffs. They sometimes argue that medical professionals are in a better position than juries to determine whether a doctor committed an error. But the numbers tell a different story. By any measure, it is clear that the number of medical errors far outstrips the number of lawsuits.

A . Only a small percentage of medical errors result in lawsuits

Twelve years ago, Harvard researchers using a sample of hospitalizations in New York State found that only one in eight medical errors in hospitals results in a malpractice claim.¹ Researchers replicating this study made similar findings in Utah and Colorado in the year 2000.² See Figure 1.

Figure 1



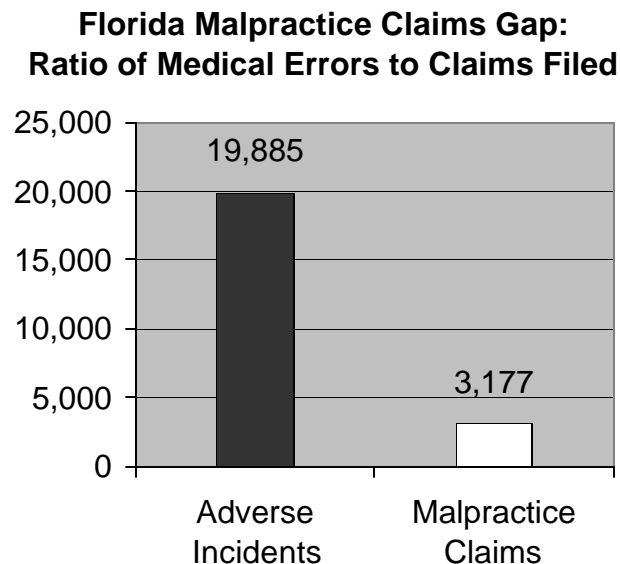
Source: Harvard Medical Practice Study Group, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990); Studdert et al, "Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado," 33 *Ind. L. Rev.* 1643 (2000).

Public Citizen was able to make analogous statewide comparisons of actual reports of medical errors to actual reports of malpractice claims and claim payments. Our findings were similar: in states with thorough reporting of medical errors in hospitals (where two-thirds of malpractice claims occur), roughly one in eight medical errors results in a payment to the injured patient. Even though these injuries are significantly under-reported, the number of medical injuries self-

reported by hospitals still greatly exceeds the number of medical malpractice verdicts and settlements.

Florida. A Florida statute requires hospitals to report "adverse incidents," defined as "an event over which health care personnel could exercise control" that results in death or injury. Tables prepared by Florida's Agency for Health Care Administration have compared reports of adverse incidents to filing of new malpractice claims. From 1996 through 1999, Florida hospitals reported 19,885 incidents but only 3,177 medical malpractice claims.³ In other words, for every 6 medical errors only 1 claim is filed. (See Figure 2) Among the errors reported in 2001 were: 9 incidents of surgery performed on the wrong patient; 16 incidents where the wrong procedure was performed; 54 incidents where the procedure was performed on the wrong site; and 122 incidents where a foreign object was left in a patient after surgery. Source-see the Florida report.

Figure 2



Source: The Agency for Health Care Administration; Division of Health Quality Assurance. Reported malpractice claims by district compared to reported adverse incidents 1996, 1997, 1998, 1999.

Other states. On hospital discharge forms, health information management specialists are asked to record an "external cause of injury," or "E-code" for a patient. A number of codes correspond to "medical misadventures" during surgical and medical care.

Adverse events characterized as "misadventures" include accidental cuts during surgery, foreign objects left in a patient during surgery, infections caused by failure of sterile precautions, and performance of inappropriate operations. They do not include abnormal reactions and other complications that occur during medical care. A misadventure does not necessarily constitute "medical negligence," which is a legal term of art. However, a "misadventure" would constitute malpractice if it was a deviation from the standard of care and resulted in more than momentary harm to a patient.

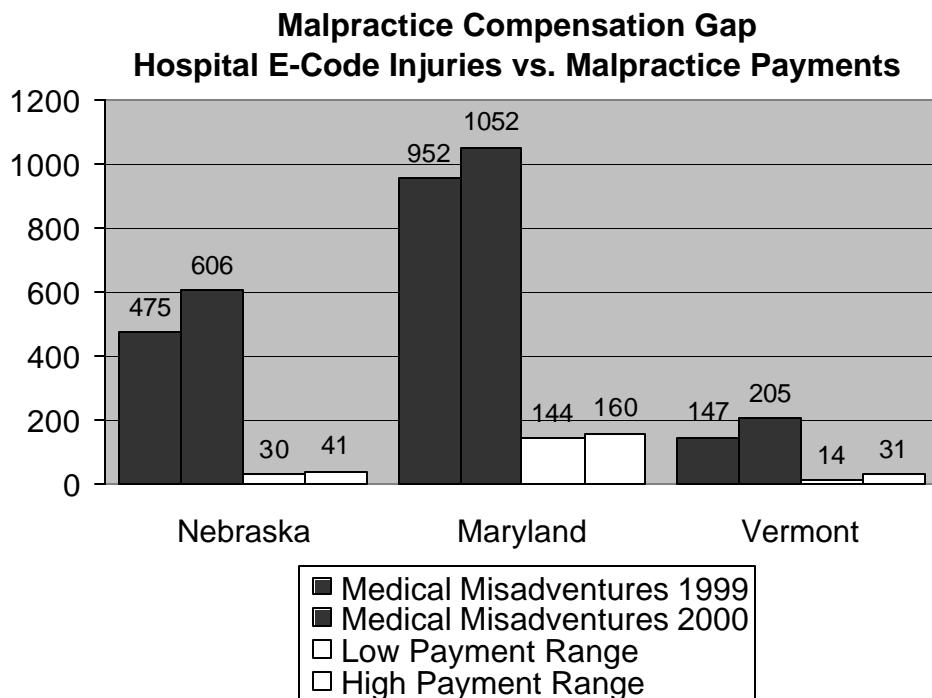
Public Citizen obtained E-code information from those states that collect such data and will supply it either for free or for less than \$100. E-codes will not capture all medical errors. "The

use of E-codes to assess medical errors has its drawbacks, including chronic under-reporting of E-codes on hospital claim forms and the lack of access to hospital discharge data in some states.”⁴ According to the U.S. Department of Health and Human Services, “as many as 95 percent of adverse events are believed to go unreported.”⁵ We gauged the completeness of a state’s hospitals’ reporting by comparing their numbers to the number of medical misadventures estimated to take place in the state by multiplying the National Inpatient Sample’s⁶ nationwide projection for 2000 of 36,909 by the percentage of the nation’s population living in a state. We found hospital misadventure data to be relatively thorough in seven states: Maine, Maryland, Nebraska, Rhode Island, Utah, Vermont, and Wyoming.

Figures 3 to 5, display the number of “misadventures to patients during surgical and medical care” reported by hospitals. In these seven states compared to the range of annual malpractice payments in the state between 1996 and 2000,⁷ as reported to the National Practitioner Data Bank,⁸ that were likely to result from hospitalization. According to Physician Insurer Association of America figures, approximately 63 percent of malpractice claims arise during hospitalization⁹ so we compare the number of misadventures to 63 percent of the actual payments.

In a world with "runaway litigation," the number of malpractice claims would far exceed the reported incidents of medical misadventure. In fact, these statistics further debunk the proposition that lawsuit outcomes are irrational and not related to actual negligence. For instance, Nebraska hospitals reported 475 medical misadventures in 1999, and 606 in 2000 (See Figure 3). Yet we estimate that during the period between 1996 and 2000, the number of medical malpractice lawsuit judgments and settlements attributable to injuries during hospitalization ranged from 30 to 41. Assuming a 1:2 ratio of claims denied by judges and juries to claims paid,¹⁰ the total number of lawsuits pursued as a result of those errors ranged between 45 and 60. Thus, fewer than ten percent of the medical errors in Nebraska in 1999 (475) and 2000 (606) result in lawsuits.

Figure 3

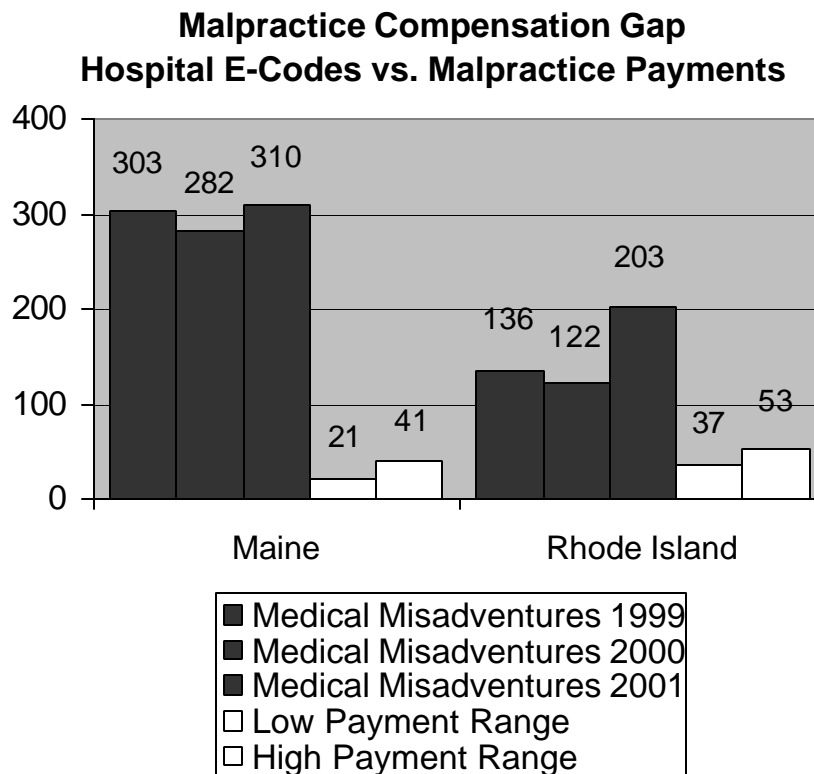


Source: Nebraska Department of Health and Human Services, Maryland Health Services Cost Review Commission, Vermont Department of Health Statistics, National Practitioner Data Bank.

Maryland hospitals reported 952 medical misadventures in 1999, and 1052 in 2000. Yet we estimate that during the period between 1996 and 2000, the number of medical malpractice lawsuit judgments and settlements attributable to injuries during hospitalization ranged from 144 to 160.

Vermont hospitals reported 147 medical misadventures in 1999, and 205 in 2000. Yet we estimate that during the period between 1996 and 2000, the number of medical malpractice lawsuit judgments and settlements attributable to injuries during hospitalization ranged from 14 to 31.

Figure 4



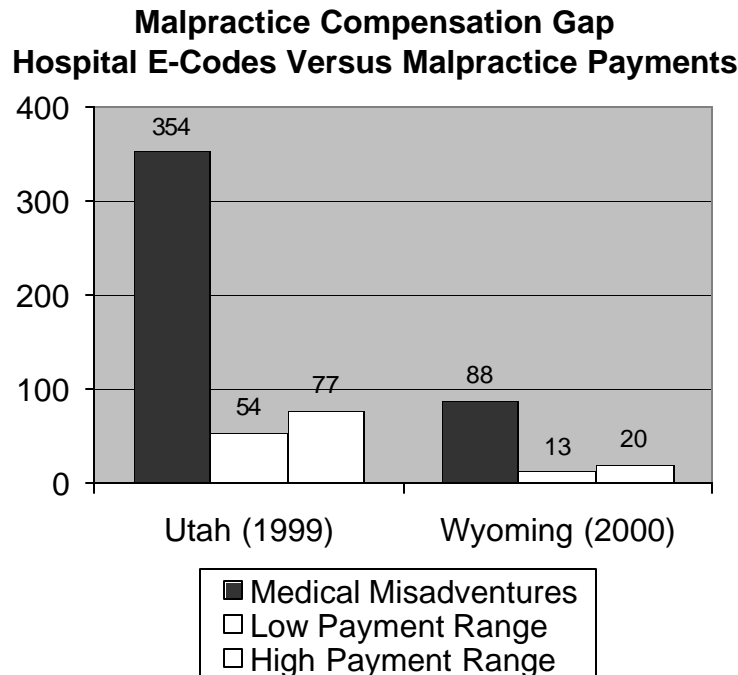
Source: Maine Health Data Organization, Rhode Island Department of Health, and National Practitioner Data Bank.

Maine hospitals reported 303 medical misadventures in 1999, 282 in 2000, and 310 in 2001. (See Figure 4) However, statistics indicate that annual malpractice verdicts and settlements there involving inpatient injuries have ranged between 21 and 41. In Maine, only about one in eight medical errors results in a lawsuit.

Rhode Island hospitals reported 136 medical misadventures in 1999, 122 in 2000, and 203 in 2001. However, statistics indicate that annual malpractice verdicts and settlements there involving inpatient injuries have ranged between 37 and 53. In Rhode Island, at most about one in four medical errors results in a lawsuit.

Utah hospitals reported 354 medical misadventures in 1999, but malpractice payments have ranged from 54 to 77. Wyoming hospitals reported 88 medical misadventures in 2000, but malpractice payments have ranged from 13 to 20. (See Figure 5)

Figure 5



Source: Utah Department of Health, Wyoming Department of Health, National Practitioner Data Bank.

B. Few lawsuits are driven by “adverse results”

Doctors say that “malpractice claims occur mainly from adverse results rather than actual error.”¹¹ They believe that patients sue out of dissatisfaction with the outcome of treatment, not because of negligence. A lawsuit brought merely because the patient experienced an adverse result, without any indication of negligence, would be a frivolous lawsuit.

How many such frivolous lawsuits are brought nationwide? The nationwide National Inpatient Sample estimate of total adverse effects of medical care in 2000 was 710,000. The Harvard Medical Practice Study estimated that about 27 percent of such events are the result of negligence,¹² but for purposes of making a conservative estimate, we will assume that none of these are. We estimate that the total number of malpractice claims made, but not resulting in payments to plaintiffs, averages around 49,000 annually.¹³ About 31,000 of these probably involve inpatient injuries. The number of claims brought per adverse result is about 4.4 percent. Using a generous assumption that half of all denied claims are brought in bad faith (which we do not believe to be the case; see Section V), the incidence of “frivolous” claims per adverse result would be about two percent. As explained in Section V, about half of these will be dropped by patients after completing an investigation. In all, hardly the “runaway train” decried by doctors.

C. Why So Few Claims?

Doctors benefit from a unique set of factors that discourage lawsuits against them. The first is the generalized aversion to conflict and hassle that is part of human nature. There may be community pressure against suing, especially in small urban and rural areas. It appears that only about one-third of victims of torts who have sustained personal injuries ever consult with a lawyer.¹⁴ These human factors are magnified in medical negligence cases. People are reluctant to sue the local doctor or hospital upon which their friends and neighbors rely. Patients generally trust their doctors, and give them the benefit of the doubt, especially those who show an interest and take the time to talk to the patient or their family members. Medical injuries occur in the presence of serious pre-existing disease, which often require all of the patient's focus and energy to deal with.

The high economic hurdles to bringing a medical malpractice suit winnow out many more potential claims. Attorneys screen out many cases. Often by the time a patient consults with a lawyer, the statute of limitations has already expired. In Florida, as in many other states, the requirements of proof in medical malpractice cases are greater than those for other types of litigation. In Florida, the testimony of a medical expert is, as a practical matter, mandatory. That's not true in any other kind of case. Attorneys must advance significant out-of-pocket expenses for consultants, expert witnesses, and discovery costs. These expenses discourage attorneys from taking on close-call cases. In many cases the damages potential will not be large enough, though the case is meritorious, to justify the investment in costs and time by the attorney. This especially discourages claims by elderly or retired patients whose damages lack a high monetary value.

Medical professionals have argued that juries are too sympathetic to injured plaintiffs to rationally evaluate claims of medical malpractice. In fact, most Americans place great credence in the medical profession. This deference can clearly be seen in comparing jury verdicts involving doctors with other categories of defendants.

Table A

Table A compares the plaintiff recovery rate among nine categories of tort cases in a 1992 study of jury verdicts by the Bureau of Justice Statistics. The overall recovery rate for plaintiffs was 49.9 percent, but plaintiffs won only 30.3 percent of medical malpractice trials.

Category of Tort Case	Plaintiff Recovery Rate in 1992
Toxic Substances	74.0%
Automobile	60.2%
Professional malpractice	50.3%
Intentional tort	46.4%
Other tort	46.5%
Premises liability	43.7%
Slander/libel	41.6%
Product liability	40.5%
Medical malpractice	30.3%

Source: Bureau of Justice Statistics, Civil Justice Survey of State Courts, 1992.

Table B

Table B compares the plaintiff recovery rate among ten categories of tort cases in the Bureau of Justice Statistics’ most recent study of jury verdicts. The overall recovery rate for plaintiffs was 47.5 percent, but plaintiffs won just 23 percent of medical malpractice trials.

Category of Tort Case	Plaintiff Recovery Rate in 1996
Automobile	57.3%
Intentional tort	55.9%
Asbestos	55.1%
Other negligence	51.9%
Premises liability	37.9%
Professional malpractice	36.2%
Slander/libel	36.0%
Breast implant	34.2%
Other product liability	30.9%
Medical malpractice	23.0%

Source: Bureau of Justice Statistics, Civil Tort Trials and Verdicts, 1996.

Table C

Table C compares plaintiff recovery rates at trial among types of medical malpractice cases. Doctors clearly do better than institutional defendants in malpractice trials.

Type of Medical Malpractice Case	Plaintiff Recovery Rate at Trial
Medical Malpractice Overall	34%
Hospital Malpractice	50%
Doctor and Hospital Malpractice	35%
Doctor Malpractice	30%

Source: Jennifer E. Shannon and David Boxold, "Medical Malpractice: Verdicts, Settlements, and Statistical Analysis," Jury Verdict Research, 2002.

Finally, negligent doctors benefit from the “conspiracy of silence” within the medical community. Most physicians are reluctant to testify against a colleague. In fact, in many states, the state medical schools flatly forbid the physicians on their faculties from acting as expert witnesses in cases involving physicians licensed in the same state. The result is that plaintiffs, as a practical matter, must find their experts outside the immediate geographic area, usually outside the state. This adds substantial cost to the processing of medical malpractice cases. Experts who agree to review records and testify can and do charge substantial fees for their time and trouble.

Even though the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) require disclosure of unanticipated outcomes in medical treatments and procedures to obtain accreditation, physicians are schooled in ways to comply without implying liability. For example, MAG Mutual Insurance Company teaches their insureds “not to use words, which might imply negligence (e.g., error, wrong, mistake, accident) and do not make disparaging comments about persons, products or organizations or engage in fingerpointing.”¹⁵ MAG Mutual Insurance Company is the largest physician-owned mutual medical professional liability insurer in the Southeast, insuring over 10,000 physicians, hospitals and other healthcare providers. The Doctors Company counsels that “if you are a consulting physician, particularly in a second

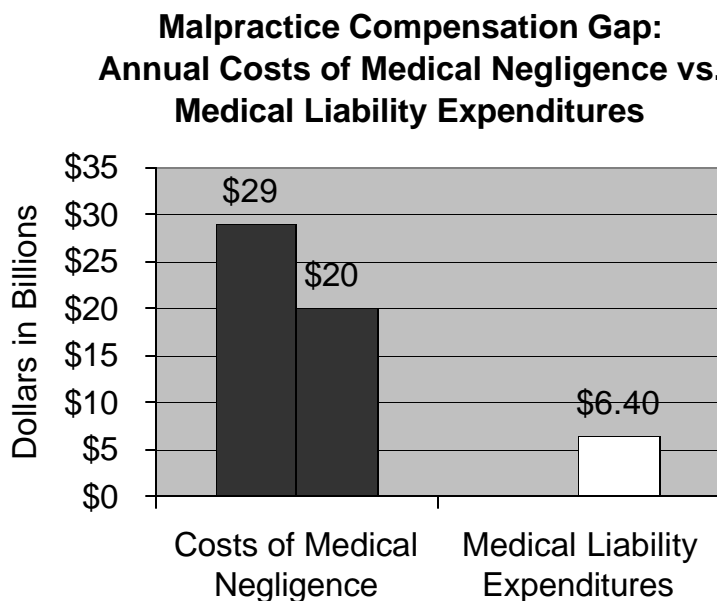
opinion situation, you should make every effort to avoid communicating any criticism of a colleague by word or action. Since you were not present during the initial treatment, it is vital that you maintain the position that you don't know why or how it happened."¹⁶

Gradually the courts awoke to the so-called "conspiracy of silence." This is why courts gradually abandoned the "locality rule," and allowed testimony from experts outside the immediate community involved.

D. Overall Tort Expenditures Are Less than the Cost of Medical Injuries

Because so few medical injuries result in compensation to patients, the overall expenditures made for medical liability are far below the projected injury costs (See Figure 6). The Institute of Medicine estimated the costs of preventable medical injuries at between \$17 billion and \$29 billion.¹⁷ The Utah-Colorado Medical Practice study estimated it at \$20 billion.¹⁸ By contrast, the National Association of Insurance Commissioners reports that the total amount spent on medical malpractice insurance in 2000 was \$6.4 billion.¹⁹

Figure 6



Source: Institute of Medicine, *To Err is Human* (2000); Studdert et al, "Beyond Dead Reckoning Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado," 33 *Ind. L. Rev.* 1643 (2000). NAIC, *Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000* (2001). American Tort Reform Association, "179 Billion U.S. Tort System Costly, Inefficient," www.atra.org

Even the questionable numbers trumpeted by the American Tort Reform Association (ATRA) do not exceed the estimate of injury costs attributable to preventable medical errors. The most recent Tillinghast-Towers-Perrin study of medical liability costs gave a total cost of \$20.9 billion.²⁰ ATRA refuses to provide details of this study, but we do know that Tillinghast includes expenditures for product liability related to drug and medical devices to inflate their medical liability figure by as much as \$10 billion.²¹

This malpractice compensation gap helps explain why, although medical injuries are costly, expenditures on medical liability comprise less than one percent of overall health care costs. As the Congressional Budget Office reported, “ Malpractice costs account for a very small fraction of total health care spending; even a very large reduction in malpractice costs would have a relatively small effect on total health plan premiums. In addition, some of the savings leading to lower medical malpractice premiums—those savings arising from changes in the treatment of collateral-source benefits—would represent a shift in costs from medical malpractice insurance to health insurance.”²²

II. Empirical Evidence Does not Confirm the Existence of “Defensive Medicine”

According to Common Good, which advocates liability relief for medical providers, “it is clear that the practice of medicine and the delivery of medical care are significantly influenced and shaped by fear of malpractice claims and perceived unreliability of the current system of justice.”²³ Medical providers surveyed by Common Good say that they often take unnecessary precautions, such as ordering unneeded tests, to avoid potential liability.

A search of the scholarly literature on medicine will turn up dozens of studies documenting the incidence of medical errors, but not one peer-reviewed study documenting the incidence of purely defensive medicine. If only we could laugh at this spectacle of a lobbying campaign constructed around a flimsy theory unsupported by any empirical evidence. Unfortunately, the evidence *disproving* the theory is so overwhelming and compelling as to be truly frightening. Here are four recent accounts demonstrating how current disincentives to unsafe and sloppy practices are inadequate, and how much more dangerous medical care would be if deterrents were further weakened.

Surgery on Wrong Patient

According to a study published in the *Annals of Internal Medicine*, New York hospitals reported 27 instances of invasive procedures performed on the wrong patient between April 1998 and December 2001.²⁴ There were nine such instances in Florida last year.²⁵ In trying to determine how such shocking errors could occur, the researchers analyzed one case in detail. The case study determined that medical personnel had ignored “many seemingly clear signals that they were subjecting the wrong patient to an invasive procedure.” In this case, “defensive medicine” measures would have included follow-up questioning or record-checking when the patient told personnel she had not been admitted for cardiac treatment. Surely if the medical providers were frightened of lawsuits they would have made such minimal inquiries.

Medication Errors

Two recent studies have found numerous errors in administering medication to hospitalized patients. An Auburn University study of 36 hospitals and nursing homes in Colorado and Georgia found that on average, 19 percent of medication doses were given in error, with 7 percent judged to be potentially harmful.²⁶ The authors said this amounts to about 40 potential adverse drug events per day in a typical 300-patient facility. The errors were made in spite of the

presence of observers from the research team—who could easily have been called as witnesses in a medical liability lawsuit. An earlier study by Boston researchers estimated that there are some 500 preventable adverse drug events in the average hospital each year, in spite of the fact that “drug injuries frequently result in malpractice claims, and in a large study of closed claims... accounted for the highest total expenditure of any type of procedure-related injury.”²⁷

Mammography Errors

The *New York Times* reported in June 2002 some very disturbing facts about errors committed by radiologists in reading mammograms.²⁸ The theory of defensive medicine predicts that radiologists would err on the side of caution, and detect more false positives than false negatives. Unfortunately the opposite is true, with studies indicating that some doctors and clinics miss as many as 1 in 3 cancers. Despite the possibility of lawsuits, doctors with no aptitude for mammography continue to read mammograms. Clinics continue to employ doctors who read too few mammograms to keep their skills sharp. It appears that only reviews by regulators spur doctors and clinics to meet minimum standards.

Hospital Infections

The *Chicago Tribune* reported in July 2002 that some 75,000 Americans die each year because of infections acquired in hospitals that “were preventable, the result of unsanitary facilities, germ-laden instruments, unwashed hands and other lapses.”²⁹

If medical providers fear being sued over the slightest lapse, why would doctors and nurses neglect to take the most elementary precautions of washing their hands and changing scrub uniforms? Why would American hospitals “have collectively pared cleaning staffs by 25 percent since 1995”?³⁰ Previously, consultants retained by medical provider groups have argued that medical providers *overspend* on precautionary measures by 5 to 9 percent.³¹

The Congressional Budget Office was recently asked to quantify the savings from reduced “defensive medicine” if Congress passed H.R. 4600, which passed the House in September 2002, and contained very stringent restrictions on patients’ ability to recover damages. The CBO declined, saying:

Estimating the amount of health care spending attributable to defensive medicine is difficult. Most estimates are speculative in nature, relying, for the most part, on surveys of physicians' responses to hypothetical clinical situations, and clinical studies of the effectiveness of certain intensive treatments. Compounding the uncertainty about the magnitude of spending for defensive medicine, there is little empirical evidence on the effect of medical malpractice tort controls on spending for defensive medicine and, more generally, on overall health care spending.

A small number of studies have observed reductions in health care spending correlated with changes in tort law, but that research was based largely on a narrow part of the population and considered only hospital spending for a small number of ailments that are disproportionately likely to experience malpractice claims. Using broader measures of spending, CBO's initial analysis could find no statistically significant connection between malpractice tort limits and overall health care spending. Although the provisions of H.R.

4600 could result in the initiation of fewer lawsuits, the economic incentives for individual physicians or hospitals to practice defensive medicine would appear to be little changed.³²

III. Increases in Medical Malpractice Payments Track Increased Costs of Injuries

At a July 2002 congressional hearing, Dr. Richard Anderson of The Doctors Company complained that “since 1990, [malpractice] claims costs have risen annually by 6.9 percent, nearly three times the rate of inflation.”³³ In fact, statistics demonstrate that trends outside the liability system have made the costs of injuries higher. There is no evidence that verdicts have risen out of proportion with general social trends.

The doctors’ lobby often blames juries for the size of medical liability awards. But that is like blaming real estate appraisers for a crunch in affordable housing. The jury, like the appraiser, determines a value by applying a general economic analysis to an individual case. Neither a juror nor the appraiser may arbitrarily substitute his or her own ideas for the formula each is legally bound to follow.

A jury’s award of damages for a catastrophic injury includes several components: *wage loss*, *medical expense*, and so-called *non-economic loss*. Non-economic losses include physical pain and suffering, physical impairment and disfigurement, loss of use or enjoyment of the pleasures of every day life, loss of love and affection and other intangibles.

Wage loss, medical costs and non-economic damages must be analyzed in terms of past and future losses. Calculation of future damages requires consideration of future work life expectancy and life expectancy. The numbers associated with each of these components are drawn from market and social forces that occur entirely outside the court system. If any of those numbers rise, the amount of verdicts will rise to reflect those trends.

- **Higher incomes.** According to the U.S. Census Bureau, median household income has risen by an average of about \$1,000 each year, more than doubling over the past twenty years from \$17,710 in 1980 to \$42,151 in 2000.³⁴ This increase reflects not only inflation but also real increases in our affluence.
- **Increased health care costs.** According to the Bureau of Labor Statistics, the cost of health care rose by about 3.5 percent per year in 1998 and 1999, 4.1 percent in 2000, 4.6 percent in 2001 and 4.7 percent through June of 2002. This is well ahead of the CPI for all items, which was 1.2 percent from January through May 2002.³⁵ However, these increases are modest given historical trends, and juries must consider those trends in predicting the cost of a plaintiff’s future medical care. Medical care services have risen at an annual rate of 6.18 percent and hospital and related services have risen by 8.28 percent annually since the government started collecting those statistics.³⁶
- **Increased life expectancy.** According to the Center for Disease Control and Prevention, since 1980 the average life expectancy in the United States has increased by three years, from 73.7 to 76.7 years.³⁷ The retirement age, set by Social Security, has also increased, resulting in

longer expected years of employment. The full retirement age is 65 for persons born before 1938. The age gradually rises until it reaches 67 for persons born in 1960 or later.³⁸

- ***Higher expectations about quality of life.*** In years past, sickness and injury were viewed as an inevitable part of life. Today, health and safety are taken for granted, and most Americans expect to live a long, healthy life. Americans place a greater value on physical activity; the International Health, Racquet, and Sportsclub Association reports that health club memberships are increasing at a 9 percent annual rate.³⁹ It is more likely today that a plaintiff will have regularly engaged in recreational or other physical activities, making a disabling injury all the more severe.

Hypothetical case. According to Jury Verdict Research, the median jury award for medical malpractice that results in paralysis is \$2.5 million.⁴⁰ While this seems like a lot of money, a computation of likely damages from a hypothetical case illustrates how jurors could reach such a verdict.

Imagine a male plaintiff, aged 40, negligently paralyzed during routine surgery due to improper administration of spinal anesthesia. Suppose the man was previously employed as a roofer, earning the median annual salary of \$35,300, and is now permanently disabled. Because of his paraplegia he would require ongoing medical care, including therapy, antibiotics to combat infections resulting from loss of bladder and bowel control, various medical devices and extensive modification of his living environment.

The plaintiff's lost wages, at \$35,300 times 27 years remaining until his retirement age of 67, would be \$953,100. This is without providing for the normal earnings increases that would typically occur during the 27-year period.

Medical and related expenses, estimated at \$25,000 per year for the rest of his life expectancy of 76.9 years, would be \$922,500 (without adjusting for inflation).

"Non-economic" damages would be awarded for permanent loss of normal functions (e.g. walking, sexual dysfunction, bowel and bladder control) and similar activities, constant pain (e.g. muscle spasms), and the inability to pursue hobbies such as hunting and fishing. If a jury fixed this loss at \$5 for each of the 16 painful hours the plaintiff would be awake each day, 365 days a year for an additional 36.9 years, this component of the award would be \$1,077,480. Total verdict: \$2,953,080.

While the median jury verdict award figure of \$2.5 million seems generous, in reality, reports PIAA, the average payment between 1985 and 2001 for a "grave injury," which encompasses paralysis, was only \$454,454.

There is no credible evidence to support the claim that jury verdicts are random "jackpots." Studies conducted in California, Florida, North Carolina, New York, and Ohio have found that jury verdicts bear a reasonable relationship to the severity of the harm suffered.⁴¹ In total the studies examined more than 3,500 medical malpractice jury verdicts and found a consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the contention that jury verdicts are frequently unpredictable and irrational.

PIAA's Data Sharing Report also demonstrates the relationship between the severity of the injury and the size of the settlement or verdict. The cumulative data from January 1, 1985 through December 31, 2001, covering 53,348 paid claims shows that the amount of the payment increases as the severity of the injury increases.⁴² PIAA, as do most researchers, measures severity of injury according to the National Association of Insurance Commissioners' classifications.⁴³ The average indemnity paid per file was \$49,947 for the least severe category of injury and increased with severity, to \$454,454 for grave injuries. All researchers found that the amount of jury verdicts fell off in cases of death. The PIAA average indemnity in death cases was \$195,723. This is not surprising, as the costs of medical treatment for a grave injury are likely to be greater and pain and suffering would be experienced over a longer time period than in the case of death.⁴⁴

Malpractice premiums correlate with the insurance cycle, not rising awards

Doctors insist that the tort system is fueling increases in malpractice insurance. In reality, for much of the 1990s, doctors benefited from artificially lower premiums; now the chickens have come home to roost because insurance companies made bad business decisions. The reasons for these malpractice premium increases are the same for all insurance products – rates had previously been lowered to attract customers and cash flow when the stock market was booming; but the industry experienced poor investment returns in recent years.

According to the International Risk Management Institute (IRMI), one of the leading analysts of commercial insurance issues, "What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990s. Throughout the 1990s, and reaching a peak around 1997 and 1998, insurers were on a quest for market share, that is, they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses. In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income."⁴⁵

IRMI also noted: "Clearly a business cannot continue operating in that fashion indefinitely. Indeed, this has been the case for such long time writers of professional liability insurance as Frontier, Reliance, and P.I.E. Mutual. These companies, who suffered through several years of weakening performance, have been liquidated or are otherwise inactive."⁴⁶

Florida's Department of Insurance has approved 2001-2002 rate increases for medical malpractice insurers ranging from 6 percent to 40 percent, with the average being 26 percent.⁴⁷ As these rates have increased due to economic and management factors, the insurance rates in other categories – automobile, healthcare, property/casualty, homeowner, commercial and workers' compensation – have also significantly risen.

To put these rate hikes into perspective, the following is a list of similar insurance rate increases in Florida:⁴⁸

Health Insurance

- Rate increases are between 20 and 28 percent this year [in 2002].⁴⁹ “HIP/Vista HMO is proposing a 15.4 percent hike in monthly premiums (and) Humana HMO is proposing a 25 percent hike.”⁵⁰

Automobile Insurance

- “Despite 2001 legislation to lower automobile insurance rates in Florida, six of the top 10 writers of private passenger auto have been approved to raise rates by as much as 10.6 percent, the Department of Insurance said. Among writers of standard coverage, Allstate Insurance Co. raised rates on average statewide by 10.6 percent; USAA raised rates 5 percent, and Nationwide Mutual Insurance Co. raised rates 6 percent. Among nonstandard writers covering high-risk drivers, Allstate Indemnity Insurance Co. raised rates statewide by 11.2 percent; USAA Casualty raised rates by 3.7 percent, and Progressive Express Insurance Co. raised rates by 12.2 percent.”⁵¹
- “Several of the state’s largest auto insurers in recent weeks have received approval for rate increases that could be as high as 18 percent in South Florida, according to the state Department of Insurance.”⁵²

Homeowners Insurance

- “Florida homeowners insured by Allstate Insurance Co. will see their premiums rise an average of 15.7 percent starting in November ... The statewide increase approved by the Florida Insurance Department is lower than the 21 percent hike sought by Allstate, the state’s second-largest insurer.”⁵³
- “[Florida] Insurance Commissioner Tom Gallagher rejected State Farm’s request for an average increase of 22 percent on homeowners’ policies [in June 2002], saying it was ‘excessive and unjustified’ ... State Farm had gotten a 14 percent rate increase in January based on losses from claims. It also was allowed a 6.4 percent premium increase last year.” In response, “State Farm Florida, the state’s largest insurer, said it will stop selling new homeowners policies in the state.”⁵⁴ Moreover, “Winter Haven-based State Farm Florida was also seeking increases in property insurance rates for condominium and apartment building owners that would average 132 percent statewide.”⁵⁵

IV. Doctors’ Aversion to Settlements May Increase Malpractice Insurance Costs

Medical malpractice insurers market their product far differently than other liability insurers. As The Doctors Company, a leading doctor-owned insurer, states on its website:

When litigation is necessary, we dedicate more resources than our competitors to defend your good name. Our claims representatives and defense attorneys combine their knowledge of regional laws and jury experience to develop *aggressive, successful, defense strategies...* *We will not consent to settle without your written permission.* (emphasis theirs)⁵⁶

In other lines of insurance coverage, claims managers will dispassionately evaluate the insured’s exposure and make an objective decision as to whether the claim should be settled or fought. This rational calculation takes a back seat to pride and other emotional considerations when

medical malpractice insurance is involved. The result is that defense attorney fees are higher and verdicts are higher, pushing malpractice premiums higher.

According to A.M. Best figures cited on The Doctors Company website, the average doctor-owned medical malpractice insurer spends 32 percent of premiums on defense costs. The Doctors Company entices customers by boasting that 49 percent of its premiums are spent on defense costs.⁵⁷

Defense costs amounting to 49 percent, or even 32 percent of premiums, far exceed defense costs in other lines of insurance. According to NAIC figures, defense costs incurred as a portion of direct premiums written amount to 4.8 percent for passenger auto liability, 7.1 percent for commercial auto liability, 16.5 percent for commercial general liability, and 28.9 percent for product liability.⁵⁸

It is particularly odd for defense costs in medical malpractice cases to be as high as defense costs in product liability cases. The stakes are higher in product liability cases, because a successful claim is likely to attract more claims involving the same product; and negative publicity takes a higher toll. Moreover, defense of product liability cases requires more resources than defense of medical malpractice cases. An Ohio State University study of trial data found that the average number of lawyers defending a product liability case is 2.0, compared to 1.6 in a malpractice trial; and the average number of expert witnesses in a product liability trial is 3.0, compared to 2.5 in a malpractice trial.⁵⁹

It seems certain that it is hardball litigation tactics that substantially increase malpractice defense costs—in the case of carriers like The Doctors Company, perhaps nearly doubling them. Malpractice insurers seldom settle a case before the eve of trial, waiting until discovery is complete. They also take three times more cases to trial than other civil defendants. In 2000, the overall percentage of federal civil cases going to trial was 2.2, but 6.8 percent of medical malpractice cases went to trial.⁶⁰

In purchasing a policy from The Doctors Company and others like it, physicians choose an insurance product that could be priced as much as 25 percent higher to account for doctors' own concerns about their reputations,⁶¹ rather than choosing a conventional insurance product. The Doctors Company and Medical Assurance both use the motto "Defending your reputation" in marketing themselves.⁶² Kansas Medical Mutual Insurance Company (KaMMCO) cites "the existence of the National Practitioner Data Bank" as a reason that it is "more important than ever for health care professionals... to defend themselves against allegations of wrongdoing."⁶³

In its most recent disclosure report to the Securities and Exchange Commission, Medical Assurance explains that its "aggressive claims management philosophy may contribute to increased loss adjustment expenses compared to those of other property and casualty lines or others specializing in professional liability insurance, but [we believe] it results in greater policyholder loyalty and contributes to lower overall loss costs."⁶⁴ But if fighting claims harder results in overall lower costs, why isn't this approach taken by other types of insurers?

In reality, the liability insurance purchased by doctors is altogether different from the ordinary insurance policy. For doctors, malpractice insurance is not just a risk management tool; it is also a public relations tool. Doctors' complaints about high premiums must be viewed skeptically

when as much as a quarter of the prices quoted may pay for services entirely unrelated to managing risks of patient care.⁶⁵

A defense strategy guided by emotion rather than reason will also affect the parties' ability to negotiate rational settlements. Ordinarily, an insurer will calculate an appropriate settlement amount by predicting a jury's likely damage computation, discounting it by the odds of a defense verdict, and subtracting litigation costs. But, as Dr. Anderson noted in his July 17, 2002 testimony, "in most cases it is the physician, not the company, who must make any settlement decision." Evidence indicates that the negotiation process in medical malpractice cases fails, directly leading to the high verdicts that doctors complain about.

The Ohio State study compared medical and product liability negotiations. It found that product liability defense attorneys "correctly" predicted jury outcomes (rejected plaintiff demands that were higher than the jury's eventual verdict) in 12 of the 14 cases studied. By contrast, defense attorneys made the correct settlement decision in only 8 of 17 medical malpractice cases in the study. In one case, the defendant rejected a demand of \$2 million only to be hit with a judgment for more than \$8 million. The authors concluded that, "In malpractice cases, plaintiffs gained more than defendants from rejecting settlement offers and proceeding to trial. In product liability cases, defendants gained more than plaintiffs from eschewing settlement and defending claims in court... It appears that malpractice defendants—rather than plaintiffs—may be somewhat too inclined to resist settlement and push cases to trial."⁶⁶

The much greater willingness of malpractice defendants to "bet the farm" at trial explains the central importance to doctors of capping non-economic damages. According to McGeorge School of Law researchers, a \$250,000 cap on non-economic damages reduces the average malpractice award by 28 percent.⁶⁷ The cap permits insurers to settle fewer cases before trial, secure in the knowledge that exposure is limited if the jury decides for the plaintiff.

One of the medical community's criticisms of the tort system has been that it "is an extremely inefficient mechanism for compensating claimants—returning less than 45 cents on the dollar to claimants."⁶⁸ If doctors are going to offer this argument, they must be made to fully disclose the extent to which they themselves contribute to the problem. Saint Paul was an insurance company that was in the vanguard of reducing its defense attorney costs, using a sophisticated computer program to track and reduce them. Now cost-conscious Saint Paul has left the medical liability market almost entirely to doctor-owned mutual insurers. It seems plausible to us that some of the jump in premiums that are shocking doctors may be attributable to the mutual companies' permissive attitude toward defense costs. It is incumbent on the mutual insurers to demonstrate that this is not true.

V. Few, If Any, Malpractice Lawsuits Are "Frivolous"

The term "frivolous lawsuit" can have two meanings: a lawsuit could be frivolous in that it alleges only *trivial* harm, or frivolous in the sense that it is clearly *not merited by the facts or the law*.

Are most malpractice lawsuits trivial?

According to PIAA, of the 5,983 claims its members reported closing in 2001, only 6.7 percent involved injuries of NAIC level 1 or 2 severity (“emotional injury only” or “insignificant injury”). Despite their minor nature, about a quarter of these claims were paid, a rate similar to the overall rate of payments.

By contrast, PIAA reports that the four conditions *most likely* to be involved in malpractice claims are quite serious: breast cancer, brain-damaged infants, injuries to a mother during pregnancy, and heart attacks.

Are most malpractice lawsuits non-meritorious?

On average about 30 percent of all medical malpractice claims files are closed with a payment to the claimant.⁶⁹ One could argue that means 70 percent (those closed without payment) are frivolous. But the tremendous cost and effort required to prepare a plaintiff’s malpractice case for trial discourage the pursuit of a weak case, and PIAA numbers indicate that more cases are dropped than are taken to trial.

Claimant’s attorneys are invariably paid via a contingency fee agreement. This means the attorney receives payment only in the event there is a settlement or verdict. Usually the agreement provides that the attorney will receive one-third of the net recovery. If the claim is closed without payment, the attorney does not receive a fee. Since attorneys must earn money to stay in business, it follows that they would not intentionally take on a non-meritorious case.

Medical malpractice cases are very expensive for plaintiff’s attorneys to bring, with out-of-pocket costs for cases settled at or near the time of trial (when most cases are settled) ranging from \$15,000 to \$25,000. If the case goes to trial, the costs can easily be doubled.⁷⁰

An attorney incurs expenses beginning with the determination of whether a case has merit. First, the attorney is required to obtain copies of the patient’s medical records from all the providers for analysis by a competent medically trained person. If that initial consultation reveals a likelihood of medical negligence, the records must then be submitted to medical specialists, qualified to testify in court, for final review. Typically, the records must be sent to experts outside of the plaintiff’s state, as physicians within the state will refuse to testify against local colleagues. As a result, the experts who agree to review records and testify can and do charge substantial fees for their time and trouble. Fees from \$1,000 per hour to several thousand dollars are not uncommon. According to the Physician Insurers Association of America, expert witnesses in a medical malpractice case are paid on average over \$4,800.

Expert opinion must be obtained from each area of expertise involved in the patient’s care, e.g. internist, general surgeon, anesthesiologist, etc. The more medical specialties involved in the patient’s care the more expensive the case costs will be. If the experts conclude that they can testify that malpractice took place, the lawsuit is filed and discovery begins.

Discovery involves taking the sworn testimony of witnesses and experts. Such depositions cost \$300 and up, depending upon their length and complexity. If an expert witness is deposed, the plaintiff’s attorney is charged for the witness’ preparation time and time attending the deposition. Again, there are no practical limits to how much they can charge. Depending on the number of experts involved, the costs of discovery can quickly escalate into the tens of thousands of dollars.

Occasionally you will hear of prosecutions for fraudulent and frivolous claims made for minor injuries sustained in automobile accidents. This is because the effort and expense required for bringing automobile claims is minimal—typically they are initiated simply by mailing a demand letter with copies of an accident report, medical records, bills, and a wage-loss verification from the plaintiff’s employer. In contrast, it makes no economic sense whatsoever to pursue a frivolous medical malpractice claim. There is a much higher risk, in terms of funds advanced, the difficulty of finding an expert to vouch for the claim, and unsympathetic jurors. The potential reward is lower as well, because doctors and their insurers are less likely than an auto insurer to make a settlement offer. Public Citizen is not aware of documented instances of fraudulent malpractice claiming.

Because preparation costs are so great, not only must a case be meritorious; it must also have sufficient damage potential to justify those costs. Many meritorious malpractice cases are not pursued, simply because they are not economically feasible.

Plaintiffs Drop More Claims than They Pursue

PIAA reports that between 1985 and 2001 a total of 108,300 claims were “dropped, withdrawn or dismissed.” This is 63 percent of the total number of claims (172,474) closed during the study period.⁷¹ It is unclear what portion constitutes involuntarily dismissed cases (dismissed after a motion was filed by the defendant) rather than cases voluntarily dismissed by plaintiffs. According to researchers at the University of Washington School of Medicine, about 9 percent of claims files are closed after the defendant wins a contested motion.⁷² Based on this figure, Public Citizen estimates that about 54 percent of claims are being abandoned by patients.⁷³ How should one understand the abandonment of such a large number of claims? There are several possible explanations.

- An attorney may send a statutorily-required notice of intent to make a claim, in order to toll the running of the statute of limitations and provide time to gather medical records, but upon investigation find the claim is not merited, and later drop the case.
- A patient’s attorney may commence a lawsuit in order to meet the requirements of the statute of limitations but, after collecting medical records and consulting with experts, decide not to pursue the claim.
- During discovery new facts may develop that convince the plaintiff and plaintiff’s attorney that they cannot prove medical negligence, and they decide to withdraw the claim.

The PIAA numbers indicate that plaintiffs and their attorneys are not knowingly pursuing large numbers of frivolous cases. It appears instead that in most cases plaintiffs are deciding after investigation that a claim should not be pursued and dropping it voluntarily. We estimate that the number of cases withdrawn voluntarily by plaintiffs⁷⁴ was 92,621, *ten times* the number of cases that were taken to trial and lost during that period (9,293). The percentage of claims pursued by plaintiffs to final rejection by a jury is only *five percent*.

Can the claims pursued to a defense verdict be understood as frivolous? Researchers at the American Society of Anesthesiologists arranged for pairs of doctors to review 103 randomly

selected medical negligence claims files.⁷⁵ The doctors were asked to judge whether the anesthesiologist in question had acted reasonably and prudently. The doctors only agreed on the appropriateness of care in 62 percent of the cases; they disagreed in 38 percent of cases. The researchers concluded, “These observations indicate that neutral experts (the reviews were conducted in a situation that did not involve advocacy or financial compensation) commonly disagree in their assessments when using the accepted standard of reasonable and prudent care.” The percentage of all medical malpractice claims that go to trial is only 6.6 percent, according to PIAA, meaning that the parties and their attorneys ultimately reach agreement about liability five times more often than neutral doctors do. If truly frivolous lawsuits were being pursued, we would expect the proportion of claims going to trial to exceed the 38 percent of claims on which even doctors will disagree.

The Costs of Defending Claims that Are Ultimately Dropped Are not Unreasonable

Medical liability insurers have complained about the costs of defending cases that are ultimately dropped. They fail to appreciate the professional obligation of lawyers to exercise due diligence, one that is essentially identical to the duty of physicians. The lawyer who undertakes to represent a client must rule out the possibility of proving medical negligence before terminating a claim, just as doctors must rule out the possibility that a patient is suffering from illnesses suggested by the symptoms complained of. In either case, the process incurs costs, even when it leads to dead ends. The doctor performs his duty by administering tests; the lawyer performs hers by using discovery procedures. Both of these processes have been criticized as too costly, and various means have been adopted to try to bring costs in line with likely benefits. In the case of doctors, managed care was the proffered solution. Two of the most prominent elements of managed care are utilization review, in which a doctor’s recommendations are scrutinized by the insurer’s representative; and financial incentives, by which the doctor bears some of the costs of ordering tests.

These elements of managed care are closely paralleled in litigation. Recent amendments to the Federal Rules of Civil Procedure expressly adopted the concept of “judicially managed discovery”, by which utilization of discovery procedures beyond a presumptive maximum limit must be approved by a judge. Insurers have imposed utilization reviews of defense lawyer activities, although, as noted earlier, it is unclear whether physician-owned medical liability insurers have joined this trend. Finally, plaintiffs’ lawyers are bound by a particularly harsh financial incentive: they are using their own time and money to pursue discovery activities, and are only paid for work on behalf of clients whose cases are successful.

The most striking similarity between these processes, however, is that in both medical practice and medical liability litigation, doctors are the gatekeepers. In Florida, a plaintiff’s lawyer must obtain a doctor’s opinion that the claim is meritorious before filing a lawsuit. Unless a plaintiff’s attorney has verified the possibility of malpractice, discovery may not go forward.

VI. Further Restrictions on Patients' Legal Rights Would Cut Muscle, Not Fat, from the Civil Justice System

There are three main critiques of the legal system that have been offered to justify changes to medical liability laws.

The first is that the system sometimes reaches erroneous results. Nobody would contend that any institution relying on fallible human beings is perfect. Fortunately, the legal system provides far more back-ups than other institutions in our society, through its transparency and its extensive appellate process. Judges can, and do, reverse decisions of juries when they act with passion or prejudice, as well as review decisions of lower courts. In recent years, the U.S. Supreme Court has expanded protections to defendants in civil cases much as it expanded protections to criminal defendants in the 1960s.

We are confident that few, if any, unreasonable results survive the review process. Nevertheless, legislative efforts to weed out systematic errors in the legal system are not unknown. Such efforts can come from both the left and right; for instance, rape shield laws were backed by women's rights advocates who feared that jurors could be desensitized by testimony of a victim's sexual history. Doctors have argued that jurors will lose their objectivity when confronted by a plaintiff with catastrophic injuries. It was with this rationale that some states, including Florida, have taken neurological injuries sustained at birth out of the tort system. This rationale was also used to place additional restrictions on expert witnesses. Public Citizen's concern is that complaints of systematic error will be exaggerated to justify "corrections" that are, in fact, mechanisms meant to tilt the playing field in favor of defendants.

The second critique is that the transaction costs of the civil justice system are too high. We believe that the tort system is worth its transaction costs. Unlike a bare-bones no-fault system, the tort system marshals lawyers' investigations, experts' opinions, and jurors' determinations to answer complex safety questions and set minimum standards for consumer protection. Within the category of "transaction costs" are attorneys uncovering the Ford/Firestone scandal; Erin Brockovich's investigation of the poisonings in Hinkley, California; and the work that exposed tobacco company fraud in manufacturing and marketing cigarettes.

Nevertheless, both consumers and corporations agree that unnecessary transaction costs should be cut when possible. Defense lawyers have favored reduction of document discovery, and plaintiffs' lawyers have favored limits on the length of depositions. But care must be taken to ensure that the "cost-cutting" label is not used to disguise measures that advantage one side. Just as defendants are skeptical of reducing the size of juries from twelve to six, we are skeptical of measures such as mandatory arbitration.

The third critique of the tort system is that it awards too much compensation. It is with this argument that we fully and vehemently disagree. As we have noted earlier, there is overwhelming evidence that most injuries are not being compensated. A review of the legislative record indicates that the Florida legislature has already accepted every theory, and adopted every conceivable measure, aimed at correcting systematic error and reducing transaction costs. All that remains in the medical community's agenda are proposals aimed at making it harder for plaintiffs to present valid cases and reducing compensation.

The medical community needs to say explicitly why it thinks a 6-to-1 disparity in injuries to claims is not favorable enough. Do they think it should be a 12-to-1 disparity? 20-to-1? What is their justification? The Health Care Liability Alliance has on its website a comparison of American tort expenditures to those in Japan and Denmark. Are doctors suggesting that Americans should mimic the conflict-aversion of Japanese culture or the stoicism of Scandinavian culture? Is there something wrong with us Americans? Is our individualism excessive? Debate is being driven by anecdotes, slogans, and hyperbole, without an acknowledgment or discussion of the values underlying the system.

Every reputable economist says that compensation expenditures need to be equal to injury costs in order to force an industry to exercise safety precautions. The conservative appointees to the President's Council of Economic Advisors phrased it very well in their recent report on the tort system:

[A] patient purchasing a medical procedure, for example, may be unlikely to fully understand the complex risks, costs and benefits of that procedure relative to others...In such a case, the ability of the individual to pursue a liability lawsuit in the event of an improper treatment, for example, provides an additional incentive for the physician to follow good medical practice. Indeed, from a broad social perspective, this may be the least costly way to proceed – less costly than trying to educate every consumer fully. In a textbook example, recognition of the expected costs from the liability system causes the provider to undertake the extra effort or care that matches the customer's desire to avoid the risk of harm. This process is what economists refer to as "internalizing externalities." In other words, the liability system makes persons who injure others aware of their actions, and provides incentives for them to act appropriately.⁷⁶

Measures that reduce compensation will reduce patient safety. Reducing tort system expenditures does not reduce the cost of injuries but shifts them, and ultimately increases them. While it is unfortunate that doctors have had to cope with large spikes in liability premiums, the silver lining is the message that the tort system is sending about medical errors. Publicly, doctors are saying that the tort system is out of control and needs to be fixed. But privately, we are certain, doctors are saying that they need to get their house in order, and ramp up new patient safety systems and risk management efforts.

VII. Florida Should Strengthen Oversight of the Medical Profession to Reduce Injury Costs

According to the public use file of the National Practitioner Data Bank (NPDB), which covers malpractice judgments and settlements since September 1990, only six percent, or 2,674 of Florida's 44,747 doctors, have paid two or more malpractice awards to patients (See Figure 7). These doctors are responsible for 51 percent of all payments and 47 percent of the dollar-value payments. They have paid out \$1.2 billion in damages. The two percent of Florida's doctors who have made three or more malpractice payments account for 22 percent of all malpractice. This skewed pattern persists in spite of the fact that doctors practicing in the high-risk specialty of delivering babies have been relieved of tort liability for birth-related neurological injuries.

Rather than a random, lottery-like pattern, this distribution very much resembles the pattern of drunk driving recidivism. Motor vehicle licensing bureaus have procedures in place to prevent or deter predisposed individuals from driving under the influence, such as mandatory counseling and license suspensions or revocations. Unfortunately, medical licensing boards do not use their authority with nearly as much vigor.

A Vanderbilt University study found that doctors with past records of malpractice claims can be expected to have “appreciably worse claims experience” than other doctors in future years.⁷⁷ Despite the fact that claims history predicts future claims, neither licensing boards nor the insurance market have been effective in reducing malpractice. There are over 4,000 doctors in the U.S. who have paid *four* or more malpractice claims.⁷⁸ This number can be expected to grow.

Figure 7

Number of Medical Malpractice Payments and Amounts Paid by Florida Doctors 1990-2000

Number of Payment Reports	Number of Doctors that Made Payments	Percent/Total Doctors in Florida	Total Number of Payments	Total Amount of Payments	Percent/Total Payments
All	9,655	21.58%	14,329	\$2,598,190,100	100%
1	6,981	15.60%	6,981	\$1,375,086,500	52.92%
2 or more	2,674	5.98%	7,348	\$1,223,103,600	47.08%
3 or more	915	2.04%	3,830	\$575,530,000	22.15%
4 or more	370	0.83%	2,195	\$278,165,900	10.71%
5 or more	177	0.40%	1,423	\$157,645,050	6.07%

Source: National Practitioner Data Bank. Numbers based on a universe of 44,747 Florida doctors.

Public Citizen’s examination of the NPDB database found records of 24 Florida physicians who have paid ten or more malpractice settlements. Of those 24, only 12 have been disciplined by the Florida Board of Medicine. Examples of some of Florida’s “repeat offenders” include:

- Physician Number 98892 settled 18 malpractice lawsuits between 1991 and 1997 involving improper performance of surgery. The damages added up to some \$2 million. This physician has never been disciplined.
- Physician Number 27908 worked in New York State, where he lost one malpractice suit and settled nine others for a total of \$3.7 million. Around 1991, Physician 27908 moved his practice to Florida, where he settled seven more malpractice suits for a total of \$3.3 million. This doctor, with 17 malpractice lawsuits totaling \$7 million, finally surrendered his New York medical license in 1999, 15 years after the first incident. He still has not been disciplined by Florida authorities.
- Physician 69310 practiced medicine in Indiana, where he accumulated eleven lawsuits. Around 1996 he moved to Florida and settled 4 more, paying some \$2 million in damages to injured patients. This physician has not been disciplined by either Indiana or Florida authorities.

- Florida has exported as well as imported questionable doctors. Physician Number 8269 settled 14 malpractice lawsuits in Florida between 1982 and 1992. Florida never disciplined this doctor. He moved on to Maryland, where he settled another lawsuit for \$695,000. He finally relinquished his Maryland license in 1999.

There are 1,555 physicians who have been disciplined by Florida's state medical and osteopathic boards for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses and other offenses, according to an ongoing Public Citizen project that tracks "Questionable Doctors."⁷⁹ Unfortunately, most of these doctors were not required to stop practicing, even temporarily.

The Florida Board of Medicine is dangerously lenient with doctors, repeatedly letting serious and sometimes repeat offenders off the hook. In Public Citizen's ranking of state medical boards, Florida ranked number 26 in vigilance. The ranking is based on the number of serious disciplinary actions per 1,000 doctors in each state. In 2001, nationally there were 3.36 serious actions taken for every 1,000 physicians. Florida levied 136 serious sanctions against 44,747 doctors, for a rate of 3.04 per 1,000 doctors. (To view the ranking, go to: <http://www.citizen.org/publications/release.cfm?ID=7166>.)

There are many physicians now practicing in Florida who, had they been practicing in states with more patient-protective medical boards, would have either lost their licenses to practice or at least been given a more serious disciplinary action. Because they are practicing in Florida, many have escaped with fines or letters of reprimand or concern. Most of their patients likely are not aware of their offenses. Examples of doctors who were disciplined but are currently allowed to continue practicing in Florida include:⁸⁰

- A surgeon who operated in the wrong place in the body in October 2001. He was fined \$5,000 and required to give a one-hour lecture on wrong-site surgery and take five hours of courses in risk management.
- A Florida physician who failed to recognize that on two occasions he had perforated a patient's uterus during an attempted abortion. In 1995, he was fined \$3,000, required to take continuing medical education and placed on probation for 18 months.
- A physician who surrendered his New York license in 1998 because he "practiced the profession fraudulently." Florida merely reprimanded him and fined him \$2,000 for not reporting this to the Florida board.
- A Florida doctor who in 1996 was put on a 60-month probation, fined and reprimanded for having sex with a 23-year-old patient. Based on the Florida action, Pennsylvania in 1998 took the more stringent step of suspending his license for the duration of the Florida probation period.
- A doctor whose license was revoked by New York in 1995 because he was practicing negligent, substandard care. In 1997, based on the New York action, the Florida board merely put him on probation for 60 months and required him to take classes and be monitored.

- A doctor whose license was suspended in 1999 by Illinois because he had been suspended from admitting privileges to a hospital and had failed to notify the Illinois board. Florida merely reprimanded him and imposed a \$1,000 fine.

These doctors, like the majority of Florida doctors who committed the five most serious offenses (criminal conviction; sexual abuse or sexual misconduct with a patient; substandard care, incompetence or negligence; overprescribing or misprescribing drugs; and substance abuse) weren't required to stop practicing, even temporarily.

In fact, only 36 percent of Florida's disciplinary actions in 2001 were serious – meaning license revocation, suspension, surrender or probation. When compared to the rest of the country, only two states were worse in that regard, Wisconsin (22 percent) and North Carolina (32 percent). Florida was one of only seven states in which the percentage of actions that were serious was less than 50 percent.

In 47 percent of the disciplinary actions taken by Florida over the past decade, the most serious action against an individual doctor was a fine. The national average was 8 percent, which means that Florida is six times as likely as other states to use a fine as the most serious disciplinary action against a doctor.

When it disciplines a doctor for substandard care, Florida is more than three times as likely as all of the states to impose a fine as the primary disciplinary action and barely more than half as likely to revoke, suspend or seek surrender of a license, or put a doctor on probation. Of the 828 primary disciplinary actions (the most serious against an individual doctor) taken over the past decade against doctors in Florida for substandard care – one of the categories of serious offenses – 63 percent were fines and only 34 percent involved even temporary loss of license (revocation, suspension or surrender) or probation. For all of the states in Public Citizen's Questionable Doctors database, only 20 percent of the primary actions taken for substandard care in the past 10 years were fines, and 63 percent were serious disciplinary actions.

This trend means that there are now many physicians practicing in Florida who, had they been practicing in states with more patient-protective medical boards, would have either lost their licenses to practice or at least been given a more serious disciplinary action. Because they are practicing in Florida, many have escaped with fines or letters of reprimand or concern, to the detriment of their patients.

Negligent doctors are rarely disciplined with loss or suspension of their license for inferior care. Instead, state medical boards focus on more easily documentable offenses such as prescription drug violations and fraud convictions or disciplinary action in another state as potential indicators of substandard care. To date, most medical malpractice legislation on the state level has sought to punish the victim instead of disciplining the perpetrator. Legislative attention must be given to requiring states to significantly improve the disciplining of physicians in order to prevent future death and injury:

1. Reform medical board governance. States should sever any remaining formal, debilitating links between state licensing boards and state medical societies. Members of medical boards (and separate disciplinary boards, where present) should be appointed by the governor, and the

governor's choice of appointees should not be limited to a medical society's nominees. At least 50 percent of the members of each state medical board and disciplinary board should be well-informed and well-trained public members who have no ties to health care providers and who, preferably, have a history of advocacy on behalf of patients. The governor should appoint members to the Medical Board whose top priority is protecting the public's health, not providing assistance to physicians who are trying to evade disciplinary actions.

2. Beef up medical board funding and staffing. State legislatures should permit medical boards to spend all the revenue from medical licensing fees, rather than being forced to give part to the state Treasury. The medical boards should raise their fees to \$500 a year. All boards could benefit from hiring new investigators and legal staff. Boards should employ adequate staff to process and investigate all complaints within 30 days, to review all malpractice claims filed with the board, to monitor and regularly visit doctors who have been disciplined to ensure their compliance with the sanctions imposed, and to ensure compliance with reporting requirements. They should hire investigators to seek out errant doctors, through review of pharmacy records, consultation with medical examiners, and targeted office audits of those doctors practicing alone and suspected of poor care.

3. Require risk prevention States should adopt a law, similar to one in Massachusetts, that requires all hospitals and other health care providers to have a meaningful, functioning risk prevention program designed to prevent injury to patients. Massachusetts also requires all adverse incidents occurring in hospitals or in doctors' offices to be reported to the medical board.

4. Require periodic recertification of doctors based on a written exam and audit of their patients' medical care records.

End Notes

¹ Harvard Medical Practice Study Group, Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York (1990).

² Studdert et al, “Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado,” 33 Ind. L. Rev. 1643 (2000).

³ The Agency for Health Care Administration; Division of Health Quality Assurance. Reported malpractice claims by district compared to reported adverse incidents 1996, 1997, 1998, 1999.

⁴ National Academy for State Health Policy, Patient Safety and Medical Errors, March 2001.

⁵ U.S. Department of Health and Human Services, Confronting the New Health Care Crisis (July 24, 2002)

⁶ The Health Care Utilization Project’s (HCUP) Nationwide Inpatient Sample (NIS) is a database of hospital inpatient stays used to identify, track, and analyze national trends in health care utilization, access, charges, quality, and outcomes. NIS contains all discharge data from 994 hospitals located in 28 States, approximating a 20-percent stratified sample of U.S. community hospitals.

⁷ Because of the “long tail” of medical liability claims—the claims arising in one year are generally not resolved until five years later—it is not possible to match medical errors occurring in 1999 and 2000 to claims arising from them. We expect that the range of payment history from the recent past will be indicative of the level of medical negligence litigation likely to ensue, as statistics collected by the National Center for State Courts show that “there has been no change in the volume of medical malpractice cases [filings] in the past five years [1996-2000].” Tort and Contract Caseloads in State Trial Courts

⁸ National Practitioner Data Bank, 2000 Annual Report, Table 7.

⁹ Physician Insurers Association of America, Cumulative Data Sharing Report, January 1, 1985 – December 31, 2001, Report 10. PIAA is a trade association with 51 insurance company members, all owned and/or operated by physicians, hospitals and other care providers. Collectively, they insure over 60% of the Nation’s practicing physicians. PIAA asserts that this is “the most detailed and largest current source of medical malpractice loss causation data available in the United States. Data has been provided by fifteen member companies located throughout the United States, with data being reported from all major geographical regions.”

¹⁰ According to PIAA Claim Trend Analysis, 2001 Edition, of claims reported to its Data Sharing Project, 52,071 were paid, either upon settlement (49,915) or after a jury verdict (2,156), while 9,293 were ultimately denied after a jury found for the defendant, a ratio of 5.6 to 1. The remainder of claims reported, 108,300, were “dropped, withdrawn or dismissed,” without distinguishing among voluntarily dismissed cases and involuntarily dismissed cases. We have made an estimate of the number of involuntarily dismissed cases (see Section V for complete discussion). By comparing the number of cases in which plaintiff ultimately recovered (52,071) to those in which a judge or jury found against the plaintiff, excluding cases that plaintiffs voluntarily dropped, we conclude that there is one denied claim for every two claims that result in payments.

PIAA Data With Public Citizen Estimate of Involuntarily Dismissed Cases

Settlements with Payment to Patient	49,915	29.4%
Verdicts for Plaintiff	2,156	1.2%
Verdicts for Defendant	9,293	5.4%
"Dropped, Withdrawn, or Dismissed"	108,300	
Estimate of Involuntarily Dismissed	15,424	9.1%
Estimate of Dropped Cases	92,876	54.7%
Total	169,664	

¹¹ Harris Interactive, Common Good Fear of Litigation Study, April 2002 at 11.

¹² Harvard Medical Practice Study Group, Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York at 3.

¹³ PIAA reports a 3:10 ratio of claims paid to claims opened, which we applied to the 14,691 reports to the NPDB of claims paid in 2000.

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- ¹⁴ See Abel, “The Real Tort Crisis—Too Few Claims,” 48 Ohio St. L. J. 443 (1987).
- ¹⁵ Disclosing Unanticipated Outcomes Under JCAHO Standard, David Tansill, JD, MAG Mutual Insurance Co. (2002)
- ¹⁶ <http://www.thedoctors.com/Resources/Handbook/Handbook99/who99.htm>
- ¹⁷ Institute of Medicine, To Err is Human (2000)
- ¹⁸ Studdert et al supra note 2.
- ¹⁹ NAIC, Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000 (2001).
- ²⁰ American Tort Reform Association, “\$179 Billion U.S. Tort System Costly, Inefficient,” www.atra.org
- ²¹ Health Care Liability Alliance, “The Impact of Liability on the Cost of Health Care Services, www.hcla.org
- ²² Congressional Budget Office Cost Estimate, H.R. 4600, September 24, 2002.
- ²³ Harris Interactive, Common Good Fear of Litigation Study, April 2002
- ²⁴ Chassin & Becher, “The Wrong Patient,” 136 Ann Intern Med. 826 (2002).
- ²⁵ Agency for Health Care Administration, Risk Management Reporting Summary, March 2002.
- ²⁶ Barker et al, “Medication Errors Observed in 36 Health Care Facilities,” 162 Arch Intern Med. 1897 (2002).
- ²⁷ Bates et al, “The Costs of Adverse Drug Events in Hospitalized Patients,” 277 JAMA 307 (1997).
- ²⁸ Moss, “Spotting Breast Cancer: Doctors Are Weak Link,” New York Times, June 27, 2002.
- ²⁹ Berens, “Infection epidemic carves deadly path,” Chicago Tribune, July 21, 2002. This number is attributed to the “Tribune’s analysis, which adopted methods commonly used by epidemiologists.”
- ³⁰ Id.
- ³¹ U.S. Department of Health and Human Services, Confronting the New Health Care Crisis (July 24, 2002)
- ³² CBO supra note 22.
- ³³ Statement of Richard Anderson Before House Energy and Commerce Committee, July 17, 2002.
- ³⁴ Table H-7. Divisions—Households (All Races) by Median and Mean Income, 1976 to 2000. U.S. Census Bureau.
- ³⁵ Consumer Price Index-Medical Care and Consumer Price Index- All Items, Bureau of Labor Statistics, U.S. Department of Labor, www.bls.gov.
- ³⁶ Calculated by William D. King & Associates, Inc. using Bureau of Labor Statistics, CPI-U Medical Care Price Index.
- ³⁷ Table 12. Estimated life expectancy at birth in years, by race and sex, National Vital Statistics Report, Vol. 50, No.6, March 21, 2002. www.cdc.gov
- ³⁸ www.ssa.gov
- ³⁹ <http://www.ihrsa.org/industrystats/opbenchmarks.html>
- ⁴⁰ 2000 Current Award Trends, Jury Verdict Research. (JVR does not receive 100 percent of the personal injury verdicts rendered nationwide and collects data unsystematically, but claims its database provides reliable descriptive statistics.)
- ⁴¹ Kelso & Kelso, Jury Verdicts in Medical Malpractice Cases and the MICRA Cap, Institute for Legislative Practice (1999). Vidmar N, Gross F, Rose M, “Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards”, 48 DePaul Law Review 265 (1998). Merritt & Barry, “Is the Tort System In Crisis? New Empirical Evidence,” 60 Ohio State Law Journal 315 (1999).
- ⁴² PIAA Data Sharing Report, Report 7, Part 10.
- ⁴³ The NAIC scale grades injury severity as follows: Emotional damage only (fright; no physical injury); Temporary insignificant (lacerations, contusions, minor scars); Temporary minor (infections, fall in hospital, recovery delayed); Temporary major (burns, surgical material left, drug side-effects); Permanent minor (loss of fingers, loss or damage to organs); Permanent significant (deafness, loss of limb, loss of eye, kidney or lung); Permanent major (paraplegia, blindness, loss of two limbs, brain damage); Permanent grave (quadriplegia, severe brain damage, lifelong care or fatal prognosis); Death.
- ⁴⁴ Vidmar, Gross, Rose, supra at 284
- ⁴⁵ Kolodkin, Charles, “Medical Malpractice Insurance Trends? Chaos!” International Risk Management Institute. <http://www.irmi.com/expert/articles/kolodkin001.asp>
- ⁴⁶ Kolodkin, Charles, “Medical Malpractice Insurance Trends? Chaos!” International Risk Management Institute. <http://www.irmi.com/expert/articles/kolodkin001.asp>
- ⁴⁷ Florida Department of Insurance, active physician rate filings effective 7/1/2001 or later; updated 7/11/2001.

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- ⁴⁸ The following quotes about state-based insurance increases are taken from a limited media survey encompassing state and national press coverage for the past two years.
- ⁴⁹ Glenn Singe, "HMO's Health Getting Better," *South Florida Sun Sentinel*, June 25, 2002.
- ⁵⁰ Charles Savage, "Medical Insurer for Miami-Area Schools Seeks Increase," *The Miami Herald*, June 8, 2002.
- ⁵¹ "Florida Auto Insurance Rates Go Up," *Best's Insurance News*, June 14, 2002.
- ⁵² Nicole Ostrow, "Auto Rates on the Way Up," *South Florida Sun-Sentinel*, June 13, 2002.
- ⁵³ Greg Groeller, "Florida Homeowners Insured by Allstate to See Premiums Rise in November," *The Orlando Sentinel*, August 21, 2002.
- ⁵⁴ David Royse, "State Farm to Stop Selling Home Policies," *The Bradenton Herald*, June 29, 2002.
- ⁵⁵ David Royse, "State Farm to Stop Selling Home Policies," *The Bradenton Herald*, June 29, 2002.
- ⁵⁶ <http://www.thedoctors.com/resources/I-27/DocBrochure/Protectdoc4-5.html>
- ⁵⁷ Id.
- ⁵⁸ National Association of Insurance Commissioners, Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000 (2001).
- ⁵⁹ Merritt and Barry, "Is the Tort System in Crisis? New Empirical Evidence," 60 Ohio St. L. J. 315 (1999).
- ⁶⁰ Query to database of Federal District Court Civil Cases, maintained by Professors Theodore Eisenberg and Kevin Clermont of Cornell University. <http://teddy.law.cornell.edu:8090/questata.htm>
- ⁶¹ If the average malpractice case is about 20 percent less complex than the average product liability case (given the lower average number of attorneys and expert witnesses involved), malpractice defense costs should be about 20 percent lower than product defense costs. By this reckoning, the portion of the malpractice premium dollar spent on defense of lawsuits should be around 23 percent.
- ⁶² See <http://www.thedoctors.com/resources/I-27/DocBrochure/Protectdoc4-5.html>, <http://www.medicalassurance.com>
- ⁶³ <http://www.kammco-msc.com>
- ⁶⁴ ProAssurance Corporation 10-K Report to SEC, April 1, 2002.
- ⁶⁵ Other "extras" that may be included in the price of malpractice insurance include Defendant Reimbursement Coverage, that pays a doctor \$500 per day to attend a trial, offered by ISMIE; and "defense coverage associated with the investigation of Medicare and Medicaid billing errors, regulatory agency actions, and... an initial consultation with an attorney to discuss potential countersuits," offered by KaMMCO.
- ⁶⁶ Merritt and Barry, "Is the Tort System in Crisis? New Empirical Evidence," 60 Ohio St. L. J. 315 (1999).
- ⁶⁷ Kelso & Kelso, Jury Verdicts in Medical Malpractice Cases and the MICRA Cap, (1999) Institute for Legislative Practice.
- ⁶⁸ Statement of Donald Palmisano Before House Judiciary Committee, June 12, 2002.
- ⁶⁹ PIAA Claim Trend Analysis, 2001 Edition
- ⁷⁰ See Vidmar, Medical Malpractice and the American Jury (1995).
- ⁷¹ Trend Analysis Report, 2001 Edition, 6b-4
- ⁷² Rosenblatt & Hurst, "An Analysis of Closed Obstetric Malpractice Claims," 74 Obstetrics & Gynecology 710 (1989).
- ⁷³ Another study, Sloan et al, Suing for Medical Malpractice, (1993) found the number was 5.9 percent. According to our queries to the database of Federal District Court Civil Cases, maintained by Professors Theodore Eisenberg and Kevin Clermont, about 4.7 percent of 10,075 medical malpractice cases between 1987 and 1992 were disposed of by pre-trial motion. To make a conservative estimate, however, we are going to use the nine percent figure.
- ⁷⁴ .09 times 172,474 equals 15,679; subtracted from 108,300 equals 92,621 claims voluntarily withdrawn. See table supra note 10.
- ⁷⁵ Posner et al, "Variation in expert opinion in medical malpractice review, 85 Anesthesiology 1049 (1996).
- ⁷⁶ Council of Economic Advisors, Who Pays for Tort Liability Claims? An Economic Analysis of the U.S. Tort Liability System (April 2002).
- ⁷⁷ Sloan et al, "Medical Malpractice Experience of Physicians: Predictable or Haphazard?" 262 JAMA 3291 (1989).
- ⁷⁸ National Practitioner Data Bank, 2000 Annual Report, Table 19.
- ⁷⁹ "Public Citizen's Florida database is available at <http://www.questionabledoctors.org/>.
- ⁸⁰ "Public Citizen's Questionable Doctors, database is available at <http://www.questionabledoctors.org/>.