

TELLING THE TRUTH ABOUT MEDICAL MALPRACTICE

A “RETORT” TO THE NATIONAL COMMISSION ON FISCAL RESPONSIBILITY AND REFORM REPORT, “THE MOMENT OF TRUTH”

December 2010

For more information contact:

Joanne Doroshow, Executive Director
Center for Justice & Democracy
joanned@centerjd.org
212/267-2801

This analysis challenges the medical malpractice findings of the National Commission on Fiscal Responsibility and Reform (“Commission”) in its December 2010 report “The Moment of Truth.” Specifically, we reject its assertion in section 3.3.12 that taking away the legal rights of injured patients would “save \$2 billion in 2015, \$17 billion through 2020.” We find that the Commission’s proposal would increase the deficit, while unfairly increasing the obstacles that sick and injured patients face in the already difficult process of seeking compensation and prevailing in court. The Commission’s recommendation will also reduce the financial incentive of institutions, such as hospitals and HMOs, to operate safely.

PATIENT SAFETY WOULD BE SEVERELY WEAKENED.

The Commission’s proposals would provide liability relief for negligent health care providers while making hospitals more dangerous. This is the wrong direction for the country given the grave state of patient safety. The Department of Health and Human Services just found that 1 in 7 patients are hurt in hospitals due to medical errors, 44 percent of which are preventable. In one year, 1.6 million Medicare patients are hurt from medical mistakes, costing the system an additional \$4.4 billion. Inasmuch as these measures would weaken the deterrent potential of the tort system, (which even the Congressional Budget Office (CBO) acknowledges¹ but does not

¹ In its October 9, 2009 letter to Senator Orin Hatch on medical malpractice issues, CBO notes, “The system has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for their losses ...” For example, the Harvard Medical Practice Study, on which the Institute of Medicine based in part its seminal 1999 book *To Err Is Human, Building a Safer Health System*, found, “[T]he litigation system seems to protect many patients from being injured in the first place. And since prevention before the fact is generally preferable to compensation after the fact, the apparent injury prevention effect must be an important factor in the debate about the future of the malpractice litigation system.” Similarly, an article in the May 11, 2006, the *New England Journal of Medicine* argued that litigation against hospitals improves the quality of care for patients. The author noted, “Anesthesiologists were motivated by litigation to improve patient safety. As a result, this profession implemented 25-years-ago, a program to make anesthesia safer for patients and as a result, the risk of death from anesthesia dropped from 1 in 5000 to about 1 in 250,000.” George J. Annas, J.D., M.P.H., “The Patient’s Right to Safety – Improving the Quality of Care through Litigation against Hospitals,” *New England Journal of Medicine*, May 11, 2006.

consider in its cost calculations), with accompanying increases in cost and physician utilization inherent in caring for newly maimed patients and for care which ultimately leads to more deaths, it is irresponsible for this Commission to make legitimate claims of potential savings until it knows those added costs.

- **Deaths.** CBO acknowledges that “imposing limits on [the right to sue for damages] might be expected to have a negative impact on health outcomes,” yet brushes aside its significance, not because it is untrue, but because it says there are too few studies on the topic. Yet of the three studies that address the issue of mortality, CBO notes that one study finds such tort restrictions would lead to a .2 percent increase in the nation’s overall death rate.² If true, that would be an additional 4,853 Americans killed every year by medical malpractice, or 48,250 Americans over the 10-year period CBO examines.³
- **Injuries.** Based on these same numbers, another 400,000 or more patients could be injured during the 10 years that CBO examined (given that one in 10 injured patients die.⁴) The costs of errors, which the Institute of Medicine put between “\$17 billion and \$29 billion, of which health care costs represent over one-half,” would clearly increase.⁵ Consider, for example, that the average length of stay per hospitalization is around 4.4 days⁶ and the average cost per day in the hospital is approximately \$2,000 per day per injury.⁷ Consider those costs in addition to physician utilization inherent in caring for these new patients. And those costs do not consider lost contributions to the workforce and tax revenues for the most seriously injured who cannot work, or for those who have died.⁸

THE COMMISSION’S PREMISE IS WRONG

The Commission’s premise, found on p. 34-35 of its report, is described as follows: “Most experts agree that the current tort system in the United States leads to an increase in health care costs. This is true both because of direct costs - higher malpractice insurance premiums - and indirect costs in the form of over-utilization of diagnostic and related services (sometimes referred to as “defensive medicine”).”

On the contrary, “most” experts do not agree with this premise at all.

² CBO says, “[t]here is less evidence about the effects of tort reform on people’s health, however, than about the effects on health care spending – because many studies of malpractice costs do not examine health outcomes.”

³ Based on 2,426,264 deaths according to the Center for Disease Control and Prevention.

<http://www.cdc.gov/nchs/FASTATS/deaths.htm>

⁴ Study of California hospitals cited in Tom Baker, *The Medical Malpractice Myth*, University of Chicago Press, 2005.

⁵ *To Err Is Human, Building a Safer Health System*, Institute of Medicine, 1999.

⁶ http://www.cdc.gov/nchs/data/injury/InjuryChartbook79-01_UtilPayment.pdf

⁷ <http://www.rtihs.org>

⁸ The U.S. work force is 154.3 million including unemployed workers generating a gross domestic product of \$14.26 trillion. As such, each worker, including the unemployed is responsible for \$92,417 of the GNP.

<https://www.cia.gov/library/publications/the-world-factbook/geos/us.html>

- **“Defensive Medicine.”** The Congressional Budget Office (CBO) found that even if the country enacted the entire menu of extreme tort restrictions, most of which are listed by the Commission,⁹ it can go no further than to find a paltry 0.5% in health care savings¹⁰. As far as so-called “defensive medicine,” CBO found only 0.3% in savings. Moreover, CBO virtually admits that to the extent “defensive medicine” exists at all, it can be controlled through simply managing care correctly as opposed to taking away patients’ rights and possibly killing and injuring more people. Specifically, CBO noted, the problem of overutilization and excessive testing is Medicare’s emphasis on “fee-for-service” spending, whereas CBO found that private managed care “limit[s] the use of services that have marginal or no benefit to patients (some of which might otherwise be provided as ‘defensive medicine’).” In other words, excessive medical testing is likely linked to private providers’ profit motive.
- **Medical Malpractice Insurance Rates.** According to 30 years of liability premium insurance history and experience, there is no correlation between enactment of tort laws and medical malpractice rate hikes.¹¹ The well-known insurance cycle is primarily responsible for medical malpractice cost increases or decreases, and that has nothing to do with the tort system.¹² In fact, the country has been in a “soft” insurance market for several years now, i.e., premiums have stabilized irrespective of whether “tort reforms” were enacted in any particular state.¹³ States with little or no restrictions on patients’ legal rights have experienced the same level of liability insurance rate changes as those states that enacted severe restrictions on patients’ rights.¹⁴

Compare, for example, Missouri and Iowa, two neighboring states. Missouri has had a cap on non-economic damages since the mid-1980s, as well as other “tort reform” in

⁹ A \$250,000 cap on non-economic damages, \$500 cap or two times the amount of economic damages, repeal of the collateral source rule, one-year date of discovery statute of limitations (3 years for children), and repeal of joint and several liability.

¹⁰ Alexander C. Hart, “Medical malpractice reform savings would be small, report says,” *Los Angeles Times*, October 10, 2009; <http://www.latimes.com/news/nationworld/nation/la-na-malpractice10-2009oct10.0.4877440.story>

¹¹ See, Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009. <http://insurance-reform.org/pr/090722.html>

¹² Insurance is a cyclical business. Its costs are cyclical as well. Three times in the last 35 years, insurance policyholders have experienced particularly large and sudden rate hikes. This is typical of what policyholders experience during the so-called “hard market” part of the insurance industry’s cycle. The cause of the hard market is always the same: a drop in investment income for insurers compounded by underpricing in prior years. When investment income drops, insurers always respond the same way: by reducing coverage, canceling policies and/or raising premiums, often dramatically. During hard market periods, insurers typically will fix their balance sheet to show an increase in “reserves” to pay claims. The increases in reserves are not the result of actual increases in claims or payouts (e.g., lawsuits, jury verdicts or other tort system costs.) Rather, they are an accounting device used by insurers to make up for previous inadequacies in reserves, hide excessive profits and justify price increases. For more detailed explanation of how the insurance cycle works, see Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009. <http://insurance-reform.org/pr/090722.html> and Tom Baker, *The Medical Malpractice Myth*, University of Chicago Press, 2005, at 45 et at.

¹³ *Ibid.* See also, Joanne Doroshow, “Here’s Really Why Your Insurance Rates Go Up - and Then Don’t,” http://www.huffingtonpost.com/joanne-doroshow/heres-really-why-your-ins_b_775077.html

¹⁴ Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009. <http://insurance-reform.org/pr/090722.html>

medical malpractice cases. Iowa has never had a cap. In the last five years studied by Americans for Insurance Reform, Missouri's pure premium increased 1 percent, while Iowa's dropped 6 percent.¹⁵ Among states that had the highest pure premium increases - more than 5 percent in the last five years - were states with significant medical malpractice limits like Florida, Nevada, and Utah.¹⁶ Moreover, there is evidence in some states that insurance premiums increased at a faster rate in states that enacted non-economic damage caps than in those that did not. In California, which has had a \$250,000 non-economic damages cap since 1975, malpractice insurance premiums increased 450 percent in the 13 years following the enactment of the cap. Only after California introduced strong insurance regulation did doctors begin to see premium relief.¹⁷

THE SPECIFIC RECOMMENDATIONS ARE UNFAIR AND COSTLY

First, the "aggressive set of reforms to the tort system" that the Commission recommends would constitute a major interference of the work of state court judges and juries in civil cases and amount to a massive and unprecedented federal preemption of traditional state common law. Many state lawmakers have specifically rejected many of these ideas. Other states have found them unconstitutional. In spite of this, the Commission recommends the following.

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

The Commission contradicts itself as it considers this measure while simultaneously recommending proposals that would specifically prevent Medicare from recovering money from jury awards. Following a successful medical malpractice lawsuit, Medicare and Medicaid can both claim either liens or subrogation interests in whatever the patient recovers, reimbursing the government for some of the patients' health care expenditures. Without the lawsuit, Medicare and Medicaid will lose funds that the government would otherwise be able to recoup.

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

¹⁵ *Ibid.*

¹⁶ *Ibid.*

¹⁷ Consumer Watchdog, "How Insurance Reform Lowered Doctors' Medical Malpractice Rates in California," March 3, 2003. <http://www.consumerwatchdog.org/documents/1008.pdf>

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

[C]ollateral source reform leads to a statistically significant increase in infant mortality... For whites, the increase is estimated to be between 10.3 and 14.6 additional deaths per 100,000 births. This represents an increase of about 3 percent. For blacks, the collateral source reversal leads to between 47.6 and 72.6 additional deaths per 100,000 births, a percentage increase between 5 and 8 percent. These results suggest that the level of care provided decreases with the passage of collateral source reform... The relationships we estimate between reform measures and infant mortality rates appear to be causal.... In summary, these results show that collateral source reform leads to increased infant mortality.”¹⁸

2) Imposing a statute of limitations - perhaps one to three years - on medical malpractice lawsuits.

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

This proposal is also superfluous and unrelated to the Commission’s goals. About 90 percent of states already have statutes of limitations for medical malpractice actions of two years or more. Most states consider a one-year statute of limitations so unfair that few states have enacted it.

3) Replacing joint-and-several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury.

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

We also note that this is not a “fair share” rule. It is unfair to injured patients. The doctrine of joint and several liability has been a part of the common law for centuries. It is a rule that applies to allocating damages when more than one defendant is found *fully responsible* for causing an entire injury. If one of them is insolvent or cannot pay compensation, the other defendants must pick up the tab so the innocent victim is fully compensated. Courts have *always* held that it applies only to injuries for which the defendant is fully responsible. That means that their negligent or reckless behavior must be an “actual and proximate” cause of the entire injury,

¹⁸ Jonathan Klick & Thomas Stratmann, “Does Medical Malpractice Reform Help States Retain Physicians and Does It Matter?” (March 8, 2004), presented at American Enterprise Institute forum, "Is Medical Malpractice Reform Good for Your Health?," Sept. 24, 2003, available at http://www.aei.org/events/eventID.614/event_detail.asp.

a high standard.¹⁹ Having said that, joint and several liability limits have already been enacted in over 40 states, so the proposal is also superfluous.²⁰

4) Creating specialized “health courts” for medical malpractice lawsuits;

No one believes health courts would save money, especially if health court proponents are taken at their word. In fact, they would significantly increase costs. For example, in their book *Medical Injustice: The Case Against Health Courts* (2007), Case Western Reserve professors Maxwell J. Mehlman and Dale A. Nance, noted, “The Republican Policy Committee states, for example: ‘The health court proposal is not about reducing costs overall (since many more people may be compensated at smaller amounts).’”²¹ These authors made the following additional observations:

Health courts “would entail some huge potential increases in total system costs.... If we take health care proponents at their word, their goal is to bring ... currently non-claiming people into the process.” This, however “would multiply the number of claims involving negligence by a factor between 33 and 50.”²²

“[C]laims involving error account for at least 84 percent of total system costs ... so that, even if we assume that only claims involving error are brought into the system, the system costs should increase by a factor of at least 28, all other things (like system efficiency) being equal.”²³

“[E]ven if we assume that the average per patient damages under a new system embracing all potential claimants (including those who claim under the existing system) would be only 30 percent of the average damages for claims now paid, that still leaves total direct system costs multiplied by a factor of about 8.5, again as a low end estimate.”²⁴

Health courts involve the creation of a new judicial or administrative bureaucracy. Costs “would certainly be substantial, vastly more than the public (taxpayer borne) judicial costs currently associated with the adjudication of malpractice claims.”²⁵

In addition to the significant cost issues, there are many other problems with health courts. Health courts force patients into an alternative system without juries, without any accountability mechanisms, without procedural safeguards, and without any meaningful appeals process. These hardships, coupled with the burden of having to prove fault or “causation,” render the injured patient virtually powerless and at the mercy of the insurance and medical industries. Even

¹⁹ See, e.g., Richard Wright, “The Logic and Fairness of Joint and Several Liability,” 23 *Memphis State Law Review* 45 (1992).

²⁰ See, e.g., Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, Appendix C, July 2009. <http://insurance-reform.org/pr/090722.html>.

²¹ Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 74.

²² *Id.* at 72.

²³ *Ibid.*

²⁴ *Ibid.*

²⁵ *Id.* at 73.

patients with catastrophic injuries, including the families of brain-damaged babies, would have to fight a “causation” battle to obtain compensation for a potential lifetime of care. Decision-makers would be heavily weighted toward health industry or business representatives, who even might have conflicting financial interests in rejecting or reducing compensation. Some proposals suggests that compensation for injuries would be determined by a benefits “schedule” (so much for a lost leg, so much for an eye) developed by the medical establishment or political appointees instead of decided on a case-by-case basis by a jury.²⁶

There are substantial constitutional problems with state and/or federal health court proposals, as well.²⁷

5) Allowing “safe haven” rules for providers who follow best practices of care.

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

First, we note that clinical practice guidelines should never be the legal basis for determining whether or not patient harm was the result of negligence. There is already a general recognition that conflict of interest and specialty bias are ongoing problems in the development of clinical practice guidelines. If medical and specialty societies are allowed to participate in writing guidelines they know will be exculpatory for their members, conflicts of interest and bias will escalate. For example, specialty societies, like the American College of Obstetricians and Gynecologists (ACOG), have been aggressive leaders in the medical lobbies’ push for liability limits in the last few years and remain committed to that goal. It would be fundamentally unjust for patients to have their cases judged by liability standards chosen by ACOG for the purpose of exculpating fellow obstetricians.

But the reality is that no matter who writes them, it is impossible to develop single authoritative guidelines for every medical condition, let alone to trust any entity to suddenly become the sole arbiter of acceptable medical practice.²⁸ It is estimated that more than 1,400 sets of clinical practice guidelines exist today. While some standards, such as those in anesthesia, are clear and easily complied with, others, such as in obstetrical cases, are complicated and can be contradictory. Moreover, as they are written for “average patients” and cannot encompass the

²⁶ See, Testimony of Neil Vidmar, Russell M. Robinson, II Professor of Law, Duke Law School before The Senate Committee on Health, Education, Labor and Pensions, “Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients,” June 22, 2006.

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

²⁸ See, <http://www.ahrq.gov/clinic/jhpl/rosoff1.htm>

huge variation in how patients present, there may be good reason to vary from a guideline's recommendation for a patient.

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

For example, in the 1990s, Maine established a program that allowed doctors in four specialties--anesthesiology, emergency medicine, obstetrics and gynecology, and radiology--to participate in a program allowing use of guidelines as exculpatory evidence in lawsuits.²⁹ Other specialties were encouraged to take advantage of this program but did not. The program expired, and the Maine Bureau of Insurance concluded, "the medical demonstration project had no measurable effect on medical professional liability claims, claims settlement costs, or malpractice premiums."

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

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

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

There is well-established evidence proving that caps on damages are harmful. Caps do nothing but stop the most severely injured patients from getting compensation.³⁰ They apply to all patients no matter how egregious the misconduct or devastating the injury. Clearly, juries are better able to determine compensation in individual cases than politicians in Washington DC.

They also have a devastating impact on Medicare patients and will add to the deficit, not decrease it. Noneconomic damages caps disproportionately hurt senior citizens, forcing Medicare to pay for their care instead of the culpable hospital's insurance company. That is because caps on non-economic damages make their cases economically impossible for attorneys to bring. The same goes for any injured person with low wages, such as women who work inside the home, children and the poor, who are more likely to receive a greater percentage of their compensation in the form of non-economic damages. In fact, this has already happened in states

²⁹ See, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2793844/>.

³⁰ A survey by the RAND Corporation found that the "most significant impact" of California's three decades-old \$250,000 cap "falls on patients and families who are severely injured or killed as a result of medical negligence or mistakes." Source: "RAND Study: California Patients Killed or Maimed by Malpractice Lose Most Under Damage Caps," Consumer Watchdog, July 13, 2004.

with non-economic damages caps, like California. Insurance defense attorney Robert Baker, who defended malpractice suits for more than 20 years, told Congress several years ago, “As a result of the caps on damages, most of the exceedingly competent plaintiff’s lawyers in California simply will not handle a malpractice case . . . There are entire categories of cases that have been eliminated since malpractice reform was implemented in California.”³¹

Where must these patients turn to cover their medical costs? The government. Obviously, this is no cost savings.

CONCLUSION

The Commission has failed to consider in any of its calculations the countervailing benefits of the legal system, which pays people for real damages that inevitably must be repaid in some way. If someone is brain damaged, burned, or rendered paraplegic as a result of health care system negligence but cannot obtain adequate compensation through the tort system, he or she may be forced to turn elsewhere for compensation, such as to taxpayer-funded health and disability programs. In other words, the costs of injuries are not eliminated, but merely shift onto someone else – the government.

³¹ See, <http://www.multinationalmonitor.org/mm2003/032003/court.html>