MEDICAL NEGLIGENCE
A PRIMER FOR THE NATION’S HEALTH CARE DEBATE
Table of Contents

• Executive Summary

• The Problem
  o Preventable Medical Errors
  o Dollars Better Spent on Patient Safety

• The Patients
  o Medical Negligence Lawsuits Few and Far Between
  o Accountability Not Jackpots

• The Insurance Industry
  o Medical Negligence a Tiny Percentage of Health Care Costs
  o Stable Claims but Rising Premiums
  o Alternative Proposals

• The Physicians
  o Doctors Are Not Fleeing the Profession
  o Physicians and Premiums
  o Practice Expenses and Income
  o Defensive Medicine

• Why We Need the Civil Justice System
  o Medical Negligence “Reform”
  o Civil Justice and Patient Safety
  o More Tort Reform Equals Worse Health Care
  o Weeding Out Dangerous Doctors

• Conclusion
Executive Summary

The Health Care Debate
Reforming the country’s health care system will be a major agenda item for the new Congress and administration. A large part of the debate will focus on the cost of health care and the driving factors behind it. In the past there has been much focus on restricting patients’ rights to hold negligent medical providers accountable, but little focus on reducing and eliminating preventable medical errors. This is partly due to the exploitation of the medical negligence “crisis” by interest groups with agendas to push. A large body of research prompted by the crisis now indicates that many of the common perceptions about medical negligence are little more than myths. This report analyzes the most recent empirical work on medical negligence in an attempt to come to a better understanding of the true challenges facing the country.

Preventable Medical Errors—The Sixth Biggest Killer in America
Preventable medical errors kill and seriously injure hundreds of thousands of Americans every year. If the Centers for Disease Control were to include preventable medical errors as a category, it would be the sixth leading cause of death in America. Yet despite this, much of the medical negligence policy debate has revolved around indirect factors, such as doctors’ insurance premiums. Any discussion of medical negligence that does not involve preventable medical errors ignores the fundamental problem. Preventing medical errors will dramatically lower health care costs, reduce doctors’ insurance premiums, and protect the health and well-being of patients.

An Epidemic of Negligence, Not Negligence Lawsuits
Despite the shocking number of medical errors, few injured patients ever file a medical negligence lawsuit, and fewer still file frivolous claims. Research shows almost all medical negligence claims are meritorious. Claims where there was no error are rarely paid and researchers have concluded the reverse—errors which are never compensated—is a far bigger problem. The reality is, as University of Pennsylvania law professor Tom Baker puts it, “We have an epidemic of medical malpractice, not of malpractice lawsuits.”

Patients Want Accountability, Not Jackpots
Far from looking for a jackpot, research shows that patients file claims because they are seeking accountability. Too often patients injured by preventable medical errors are left in the dark about what happened to them: 70 percent of patients who experience medical errors are not told by their doctors. Nearly one half of the nation’s doctors admit to not reporting incompetence or medical errors. On the other hand, hospitals and health systems that have embraced full disclosure of medical errors to patients have found that the number of medical negligence claims and their related costs declines.

Better Patient Safety Is the Key to Lower Health Care Costs
The rising cost of health care just intensifies the need to focus on preventable medical errors and their huge associated costs. The savings from preventing medical
errors run into billions of dollars. The savings from restricting patients’ access to justice, however, are negligible. Medical negligence costs amount to less than two percent of health care spending, and government economists estimate restricting all patients’ restitution would only lower health care costs by 0.5 percent or less. Preventative reforms that focus more on the medical industry rather than the legal system are a key part of any effort to making health care more affordable and accessible.

**Medical Negligence “Reform” Just Fills Insurance Company Coffers**

Limiting patients’ rights does nothing but fill the coffers of malpractice insurance companies. A large body of research has shown that claims have remained stable for decades, while insurance companies have drastically raised physician premiums to build huge surpluses. States which have enacted caps on damages have seen hospitals and malpractice insurance companies make tens of millions but not cut the prices they charge patients and health insurers. Meanwhile the cost of health care continues to rise at near-record levels.

**Doctors Are Not Fleeing**

The most frequently echoed myth concerning medical negligence is the notion that doctors are fleeing states and retiring early, creating physician shortages. Anecdotal accounts of doctors fleeing states in response to increased insurance premiums have proved to be either unrepresentative isolated events, or flat out false. In fact, data from the American Medical Association (AMA) show that physician numbers have been increasing across the board for many years. Not only are there record numbers of physicians in the U.S., the increase has also significantly outpaced population growth. There are now twice as many physicians per 100,000 population as there were when the AMA began tracking figures in the 1960s.

The number of physicians per 100,000 population is significantly higher in states without caps. This fact is supported by a large body of research that has found physician supply is not connected to insurance premiums. Researchers at the National Bureau of Economic Research (NBER) concluded, “The arguments that state tort reforms will avert local physician shortages or lead to greater efficiencies in care are not supported by our findings.”

**The Civil Justice System Makes Us Safer**

Every profession has its bad apples and physicians are no exception. Just six percent of doctors are responsible for nearly 60 percent of all medical negligence, and the civil justice system is the only effective means for holding them accountable. Other disciplinary mechanisms are woefully inadequate. State medical boards, for instance, are supposed to discipline doctors who consistently violate standards of care. Yet two-thirds of doctors who make 10 or more medical negligence payments are never disciplined at all. Hospitals are on the front lines of patient safety, yet nearly half of all U.S. hospitals have never reported a disciplinary action against one of their doctors since the National Practitioner Databank was created in 1990. Alternative compensation systems, such as health courts, propose eliminating or greatly sidelining disciplinary systems altogether.
The civil justice system holds doctors, hospitals and insurance companies accountable. It is this accountability that drives the development of patient safety systems that help prevent negligence before it occurs. Hospitals, health systems and even entire medical fields have reformed dangerous practices because of the civil justice system. Without the accountability the civil justice system enforces, patient safety will suffer and health care costs will go up for everyone.
The Problem

Preventable Medical Errors
Preventable medical errors kill and seriously injure hundreds of thousands of Americans every year. Any discussion of medical negligence that does not involve preventable medical errors ignores this fundamental problem. And while some interested parties would prefer to focus on doctors’ insurance premiums, health care costs, or alternative compensation systems—anything other than the negligence itself—reducing medical errors is the best way to address all the related problems. Preventing medical errors will lower health care costs, reduce doctors’ insurance premiums, and protect the health and well-being of patients.

The Institute of Medicine’s (IOM) seminal study of preventable medical errors estimated as many as 98,000 people die every year at a cost of $29 billion.\(^1\) If the Centers for Disease Control were to include preventable medical errors as a category, these conclusions would make it the sixth leading cause of death in America.\(^2\)

Further research has confirmed the extent of medical errors. The Institute for Healthcare Improvement estimates there are 15 million incidents of medical harm each year.\(^3\) HealthGrades, the nation’s leading healthcare rating organization, found that Medicare patients who experienced a patient-safety incident had a one-in-five chance of dying as a result.\(^4\)

Yet despite these numbers, the American public remains unaware of just how pervasive the problem is. Even though one in three Americans say that they or a family member has experienced a medical error, and one in five say that a medical error has caused either themselves or a family member serious health problems or death, surveys show that Americans vastly underestimate the extent of medical errors.\(^5\) About half of respondents believe the annual death total from medical errors to be 5,000 or less—nearly 20 times lower than the IOM’s estimate.

“We have an epidemic of medical malpractice, not of malpractice lawsuits.”

Tom Baker, Professor of Law
University of Pennsylvania

People have been led to believe that there are hundreds of thousands of medical negligence lawsuits every year and only a handful of genuine medical errors. In
reality, the reverse is true. There are very few medical negligence lawsuits, and hundreds of thousands dying from preventable medical errors. As University of Pennsylvania law professor Tom Baker puts it, “We have an epidemic of medical malpractice, not of malpractice lawsuits.”

Much of the discussion surrounding medical negligence revolves around costs, whether it be the cost of physicians’ insurance or the cost to health care. While these are the subject of much debate and acrimony, the potential savings from the elimination of medical errors are undeniable.

Dollars better spent on patient safety

<table>
<thead>
<tr>
<th>Problem</th>
<th>Cost of Problem</th>
<th>Solution</th>
<th>Effect of Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Errors</td>
<td>98,000 Deaths</td>
<td>Computerized Medical Records Systems</td>
<td>Investment of $115 billion over 15 years can produce yearly savings of $81 billion from efficiency and error avoidance7</td>
</tr>
<tr>
<td></td>
<td>$29 billion in costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Errors</td>
<td>7,000 Deaths</td>
<td>Bar Coding Medicines and Equipment</td>
<td>$7 billion in savings per year</td>
</tr>
<tr>
<td></td>
<td>1.5 million preventable Adverse Drug Events (ADEs)</td>
<td>Computerized Physician Order Entry Systems (CPOE)</td>
<td>Reduction of ADEs by 17% and serious medication errors by 55%</td>
</tr>
<tr>
<td></td>
<td>$3.5 billion in costs</td>
<td>Smart Pumps</td>
<td>Savings of $5 to $10 million (including implementation) per hospital per year 235 ADEs avoided per hospital each year10</td>
</tr>
<tr>
<td>Foreign objects retained during surgery</td>
<td>1,500 incidents of surgical tools left in patients each year</td>
<td>Radio Frequency Identification (RFID) Tags</td>
<td>Incidents of surgical tools left in patients are almost completely eliminated</td>
</tr>
<tr>
<td></td>
<td>$17.25 million in excess costs between 2000 and 200212</td>
<td></td>
<td>$8.8 billion investment over 4 years provides hospitals savings of up to $11 billion a year from enhanced inventory control13</td>
</tr>
<tr>
<td>Hospital-Acquired Infections</td>
<td>2 million hospital patients acquire infections each year14</td>
<td>Hand Washing Programs</td>
<td>Estimated savings of $57,600 a year for a 300-bed hospital17</td>
</tr>
<tr>
<td></td>
<td>90,000 people die annually from hospital-acquired infections15</td>
<td>Minimize Ventilator-Associated Pneumonia</td>
<td>Allegheny General Hospital (Pittsburgh) invested $35,000 in a program that reduced infections by 83-87 percent and returned $4.3 million in savings18</td>
</tr>
<tr>
<td></td>
<td>Cost of $4.5 billion a year16</td>
<td>Reduce Blood Infections from Central IV Lines</td>
<td></td>
</tr>
<tr>
<td>Post-Surgical Infections</td>
<td>500,000 incidences of post-operative infections per year19</td>
<td>Use of Prophylactic Antibiotics</td>
<td>Post-surgical infections drop to 1 in 200 patients20</td>
</tr>
<tr>
<td></td>
<td>Cost of $1.5 billion per year20</td>
<td>Use electric scissors instead of shaving</td>
<td>40-60 percent of surgical site infections can be prevented by using prophylactic antibiotics23</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Routine operating-room checklist21</td>
<td>Using electric clippers can save $3 billion24</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Checklist can save $15-25 billion in surgical complications costs25</td>
</tr>
</tbody>
</table>

The Center for Medicare & Medicaid Services (CMS) has, in recent years, recognized the potential for financial savings by reducing medical errors. CMS has stopped...
paying for hospital and practitioner errors, and thus created a financial incentive for hospitals to embrace patient safety. After evaluating a number of billable hospital-acquired conditions, CMS and the CDC decided on eight expensive but “reasonably preventable” secondary conditions that would not be reimbursed by Medicare, and could not be billed to patients.\(^{26}\) Previously, Medicare rewarded hospital errors with larger reimbursements, by paying them an extra amount to treat various preventable complications that developed as a result of hospital negligence.

The new rules, which went into effect in 2008, are expected to save taxpayers at least $21 million annually and will encourage hospitals to take steps to avoid “reasonably preventable” hospital acquired conditions.\(^{27}\) Private insurers like Blue Cross/Blue Shield Association and Aetna have also implemented similar policies not to reimburse medical providers for care related to problems or complications that should not occur in the normal course of hospitalization.\(^{28}\)
The Patients

Medical Negligence Lawsuits Few and Far Between
Although much attention has been given to “medical negligence liability crises,” in reality, very few injured patients ever file a medical negligence lawsuit.

In 2006, researchers at Harvard University announced the results of a study showing that most negligence claims involve medical error and serious injury, and concluded “portraits of a malpractice system that is stricken with frivolous litigation are overblown.” The researchers found that few claims were without merit, and those that were generally did not receive any money. Most negligence claims were meritorious, with 97 percent of claims involving medical injury and 80 percent involving physical injuries resulting in major disability or death. Few claims where there was not error were ever paid. In fact, researchers found the reverse—non-payment of claims where error was involved—was a bigger problem.

“In the major problem out there is medical errors that are not compensated, rather than frivolous claims that are compensated.”

William Sage, Vice Provost for Health Affairs
University of Texas at Austin

Co-author William Sage commented, “These findings are absolutely no surprise to any of us in the policy community. They are consistent with everything we suspected and learned from research over last 20 years, which is that the major problem out there is medical errors that are not compensated, rather than frivolous claims that are compensated.”

This conclusion did not surprise the patient safety movement. Kaiser Family Foundation President Drew Altman said, “Maybe the question instead of 'Why do we have so many lawsuits?' is 'Why do we have so few?'”

According to the National Center for State Courts (NCSC) only about six percent of the civil caseload is comprised of tort cases. Of that subsection, just three percent
comprise medical negligence cases. And even that tiny number has declined by eight percent over the last 10 years.\textsuperscript{32} Data from other sources such as the National Practitioner Databank, to which all physicians’ medical malpractice payments must be reported, confirms the same downward trend.\textsuperscript{33}

When the number of medical negligence payouts made every year is compared to the number of suspected deaths from preventable medical errors, it is easy to see why researchers have concluded that there are too few malpractice claims, not too many.\textsuperscript{34}

**Accountability Not Jackpots**

Another myth is that medical malpractice cases are multimillion dollar jackpots for their lucky patients. The source of such myths are private research firms like Jury Verdict Research (JVR). JVR’s self-confessed, unsystematic data-collection method relies on self-reporting attorneys and stringers, which skews the data towards more high-profile, expensive cases.\textsuperscript{35} JVR also does not account for the fact that initial verdicts are usually much reduced by the time an insurance company makes a payment to a patient, particularly if the judgment was high. Almost all (98 percent) verdicts larger than $2.5 million are eventually reduced to less than half the original award (44 percent of award).\textsuperscript{36}

In reality, while the high cost of future medical care causes malpractice awards to be high, they are far from the million-dollar awards tort reformers claim. According to the National Practitioner Databank, the median medical malpractice award was $175,000 in 2006.\textsuperscript{37} Data from the Department of Justice’s Bureau of Justice Statistics (BJS) paints a similar picture. BJS researchers examined medical malpractice insurance claims in select states and found median awards ranging from $107,000 in Missouri to $195,000 in Texas.\textsuperscript{38} Only between 5.5 percent (Florida) and 10.6 percent (Texas) of insurance payouts were for $1 million or more. A comprehensive analysis of insurance industry expenditures by Americans for Insurance Reform (AIR) similarly concluded, “inflation-adjusted payouts per doctor not only failed to increase during the last several years, a time when doctors’ premiums skyrocketed, but they have been stable or falling throughout this entire decade. Payouts (in constant dollars) have been essentially remained flat or dropped since the mid-1980s.”\textsuperscript{39}

Far from looking for a jackpot, research shows that patients file claims because they are seeking accountability. Too often, patients injured by preventable medical errors are left in the dark about what happened to them, and litigation is sometimes the only way to uncover what transpired. A Kaiser Family Foundation survey found that 70 percent of patients who experience medical errors are not told by their doctors.\textsuperscript{40} A national survey from Columbia University’s Institute on Medicine as a Profession (IMAP) similarly found that nearly one half of the nation’s doctors failed to report incompetence or medical errors.\textsuperscript{41}
The vast majority (92 percent) of the public believe that reporting serious medical errors should be mandatory and public. However, state reporting programs are plagued by underreporting, despite research from the National Academy for State Health Policy (NASHP) demonstrating that there is no relationship between mandatory reporting and increases in malpractice claims. The only national database of malpractice claims, the National Practitioners Databank (NPDB), is still closed to the public and has been deliberately undermined by the American Medical Association (AMA), which goes so far as to offer its members a primer on "How to evade a report to the NPDB."

On the other hand, hospitals that have embraced full disclosure of medical errors have found that the number of malpractice claims and their related expense declines. The Veterans Affairs (VA) hospital in Lexington, Kentucky, has been a leader in the field by offering a strong disclosure program coupled with quick and fair offers of compensation when appropriate. Average settlements at the institution are now around $15,000 as opposed to $98,000 at other VA hospitals. It is a recognition of the fact that patients are searching for accountability, not jackpots.
Malpractice a Tiny Percentage of Health Care Costs
One of the principal myths surrounding medical malpractice is its effect on overall health care costs. Medical malpractice is actually a tiny percentage of health care costs, in part because medical malpractice claims are far less frequent than many people believe.

“[E]ven a reduction of 25 percent to 30 percent in malpractice costs would lower health care costs by only about 0.4 percent to 0.5 percent.”

Congressional Budget Office

According to the Congressional Budget Office, malpractice costs amount to “less than 2 percent of overall health care spending. Thus, even a reduction of 25 percent to 30 percent in malpractice costs would lower health care costs by only about 0.4 percent to 0.5 percent, and the likely effect on health insurance premiums would be comparably small.”

Stable Claims but Rising Premiums
Empirical research has found that there is little correlation between malpractice payouts and malpractice premiums. A study by researchers at the University of Texas, Columbia University and the University of Illinois based on closed claims compiled by the Texas Department of Insurance concluded that “the rapid changes in insurance premiums that sparked the crisis appear to reflect insurance market dynamics, largely disconnected from claim outcomes.”

“[I]ncreases in malpractice payments made on behalf of physicians do not seem to be the driving force behind increases in premiums.”

National Bureau of Economic Research

Researchers from the National Bureau of Economic Research came to the same conclusion, stating, “increases in malpractice payments made on behalf of physicians do not seem to be the driving force behind increases in premiums.” The AIR analysis likewise found no relationship between insurer payouts and premiums. AIR concluded, “Not only was there no “explosion” in lawsuits, jury awards or any tort system costs to justify the astronomical premium increases that doctors have been
charged in recent years. These rate increases were rather driven by the economic cycle of the insurance industry, driven by declining interest rates and investments.\textsuperscript{50} Instead, market dynamics, such as the fluctuation of investment income according to interest rate swings, were the sole cause of increased premiums.

The conclusion of much of the empirical research is that even if tort reform saves insurance companies money, those savings are not passed on in the form of lower physician premiums or health care costs. A study of the leading medical malpractice insurance companies’ financial statements by former Missouri Insurance Commissioner Jay Angoff found that these insurers artificially raised doctors’ premiums and misled the public about the nature of medical negligence claims.\textsuperscript{51} According to the study, the amount the leading malpractice insurers projected they would pay out in claims in the future declined; the amount they actually paid out in claims declined; and their surplus—the extra cushion they have accumulated over and above the amount they have set aside to pay claims in the future—increased to an all-time high—five times the state minimum surplus for insurer stability.

A \textit{Dallas Morning News} investigation of Texas’ 2003 medical negligence cap found similar results. While hospitals and medical malpractice insurance companies made millions over the next few years, no hospital or doctor cut the prices they charged patients or health insurers. The cost of health care in Texas continued to rise at near-record levels.\textsuperscript{52}

\textbf{Alternative Proposals}

In recent years, many interest groups have proposed alternatives to the civil justice system. While none of these alternatives promise to deliver benefits that are not already achieved through the civil justice system, they do share one common theme: avoiding the accountability of the civil justice system.

\textbf{Health Courts—A Return to Managed Care}

The concept of health courts is one such alternative compensation system being pushed by corporate defense lawyer Philip Howard and his group Common Good. Though health courts’ advocates tout that the system would compensate many more patients than the civil justice system, the model health court requires injured patients first go through the insurance companies (see flow chart). This is little more than a return to managed care. A system that relies on the good faith of insurance companies, particularly when doing anything but denying the claim is detrimental to their financial health, is doomed to result in the type of widespread fraudulent denials that haunted managed care.
Health Courts Deny Injured Patients
By removing medical negligence lawsuits from the civil justice system, health courts deny injured patients their constitutional right to a jury trial. Instead of being heard by an unbiased judge or jury, each case would be heard by a health court judge, who would be selected by politicians. This political element opens up the possibility that parties with a vested interest in the outcome of cases, such as insurance companies and the medical community, would have a way to influence selections and bias the system. Additionally, there is no guarantee that the judges would be required to have any legal background.

Medical Negligence Is Not One-Size-Fits-All
Health courts would treat all injuries the same regardless of the circumstances or facts in each case. Decisions about liability and compensation would be set by a pre-determined schedule of restitution. Thus, a pianist who loses a finger would receive the same amount of compensation as a librarian, despite the vastly different professional and financial losses they would face.

Health Courts Would Be Outrageously Expensive
Health courts would be an expensive new bureaucracy. In addition to the start-up costs of implementing a health courts system, states would also have to finance the administrative expenses associated with its operation. These administrative expenses would be enormous. States are currently struggling to cover existing expenses and keep courts funded. Adding an unnecessary and costly system that denies patients’ rights should not be the priority of any government. Health courts are modeled after the workers’ compensation system, which gives some indication of the massive administrative expense that would be involved. The administrative cost of running workers compensation comes to 38 percent of all money in the system, or $33 billion. That administrative expense is significantly more than any estimate of the total cost of medical negligence, including payouts, expenses and administration. And there is every indication that a health courts system would be substantially more expensive than even workers compensation because of the higher numbers of injured victims involved and the far higher incidence of serious injury.

Health Courts and Patient Safety
Health courts would do little to improve physician dialogue about medical errors because this system does nothing to alleviate the stigma associated with making the errors. Though compensation decisions under health courts would be based on an “avoidability” standard of care rather than the traditional “negligence” standard of care, it is not clear whether health care professionals “would view injuring patients by committing avoidable errors as any less stigmatizing than injuring patients through negligence.”53 The health courts model also requires eliminating or sidelining all physician discipline mechanisms in the hope of encouraging more candor. However,

there is nothing to suggest that this will result in more candor, and everything to suggest it will merely give a free pass to the six percent of doctors who cause nearly 60 percent of all medical negligence.

**Sorry Works**

Some advocates are now pushing a program that would encourage doctors and their insurers to openly disclose medical errors, offer apologies, and provide compensation to injured patients. Several hospitals nationwide are currently implementing medical error apology programs. Each hospital’s program is different, but the standard concept of each program is the same. If a medical error occurs, programs either require or encourage hospital staff to personally disclose the medical error to the patient and apologize. The hospital then offers the patient compensation for their injuries. If the patient accepts the apology and the compensation offered, the patient is barred from filing a lawsuit against the doctor or the hospital to recover for the injuries they suffered as a result of the medical error. The goal of the Sorry Works program is to minimize errors, reduce hospital costs, and minimize the threat of litigation.

The Sorry Works Coalition, the advocacy group advancing the apology program, acknowledges that “anger—not greed—is what drives most customers to file medical malpractice lawsuits.” Indeed, research has shown that most injured patients just want to know what went wrong in the course of their treatment and the only way they can do this is through the discovery process of litigation.

The Sorry Works program is based on a policy created and implemented by the Veterans Hospital Administration. In the 1980s, patient safety at VA hospitals was dismal enough to draw scathing rebukes from both Congress and the GAO. VA hospitals had been “long notorious for serious lapses in medical safety.” It took years of action by Congress and the Department Veterans Affairs to force more disclosure of errors.

One VA hospital took a unique approach to error reporting by creating its own apology program. The Kentucky Veterans Administration Hospital in Lexington, Kentucky, launched its apology system in 1987 and showed significant results in a relatively short period of time. By 2000, that hospital had settled 170 malpractice claims and gone to trial just three times. During this period, the hospital’s average payout, across all claims, was $15,000: less than 20 percent of the VA system’s average of $98,000.

Apology programs are now in place in certain hospitals around the country. But before they are put into widespread use, some specific standards must be adopted to protect the rights of injured patients and the families of those killed by preventable medical errors.

**Hospital staff must participate in and adhere to apology programs**

Apology programs must require mandatory participation by hospital staff. While the University of Michigan Hospitals and Health Centers, Johns Hopkins Hospital, and each Veterans Administration Hospital nationwide requires staff to follow their respective apology policies, some programs currently in use merely “encourage”
hospital staff to disclose medical errors and apologize. For example, the doctors employed by the Catholic Healthcare West hospital system do not have to adhere to its apology policy because they are considered independent contractors. Lack of uniform policies will only create confusion and greater dissatisfaction with the system among injured patients and staff.

**Apology programs must provide fair compensation for injured patients**

Proponents of apology programs report that implementing an apology program will result in a reduction of the number of claims and the cost of payouts. The families of the thousands of patients killed by medical errors each year deserve compensation. The patients injured by medical errors each year deserve fair compensation for their injuries. An attorney can help fairly assess the cost of the medical injury and future health care costs, which are often a huge portion of the compensation. The attorney also provides needed transparency to the system.

**Protect apologies but not other evidence**

Apology programs can be successful in reducing medical negligence lawsuits, however, there will undoubtedly be instances where injured patients will want to, or have to, go to court in order to hold hospital staff accountable for medical errors. To encourage people to personally apologize for their mistakes, apologies should not be admissible in court to prove fault. On the other hand, if the rules of evidence permit, medical records detailing medical negligence or eye-witness accounts of events surrounding medical errors must continue to be admissible in court. Apology programs must not eliminate victims' ability to hold wrongdoers accountable.

**Medical Screening Panels**

Recently, legislators have been discussing proposals that would require injured patients to have their cases evaluated for merit by a medical screening panel before a lawsuit can be filed. Any discussion about medical screening panels needs to include provisions to protect patients' rights.

One such provision must be to keep the screening panels fair and balanced. Some proposals state that the composition of the panel must contain “not less than one” qualified medical expert, “not less than one” legal expert, and “not less than one” community representative. This wording leaves open the possibility that the balance of the panel could tip in one party’s favor. Nor do the proposals clarify who is responsible for selecting panel members and what qualifications these members must have.

Screening panel legislation must also acknowledge the statute of limitations restrictions on bringing medical negligence claims and guarantee that the clock does not start ticking until after the screening panel has reviewed the claim. Failure to delay the start of the statute of limitations while a screening panel evaluates a claim could leave an injured patient who has conscientiously complied with every step of the process without recourse.
Screening panels also need to employ a more relaxed standard regarding evidence since there is usually no discovery, and thus patients may not have access to medical records or witnesses.

**Practice Guidelines**
Physicians are expected to adhere to certain standards of treatment in their medical practices. These clinical practice guidelines of appropriate treatment are developed by health care experts and are typically understood to set the minimum standard of care.

In recent years, tort reformers have attempted to introduce these clinical practice guidelines as the legal standard of care in medical negligence cases. However, compliance with these guidelines should not provide physicians immunity from negligence claims. Such guidelines set a safety minimum and should not be used as an excuse to avoid responsibility for negligent medical care.
The Physicians

**Doctors Are Not Fleeing the Profession**
The most frequently echoed myth concerning medical negligence is the notion that doctors are fleeing states and retiring early, creating physician shortages. Anecdotal accounts of doctors fleeing states in response to increased insurance premiums have proved to be either unrepresentative isolated events, or flat out false. A Government Accountability Office (GAO) investigation found that “many of the reported provider actions taken in response to malpractice pressures were not substantiated or did not widely affect access to health care ... some reports of physicians relocating to other states, retiring, or closing practices were not accurate or involved relatively few physicians.”56 In fact, data from the AMA shows that physician numbers have been increasing across the board for many years.

- **The number of doctors is increasing.** The total number of physicians in the U.S. rose to yet another record high in 2007, the most recent year for which data is available. There were 941,304 physicians in the U.S. in 2007, nearly 20,000 more than the year before.

- **The number of doctors is increasing faster than population growth.** The increase in physicians outpaced the increase in population once again. The number of physicians per 100,000 population is at an all-time high of 307. The increase of physician numbers compared to population growth has climbed steadily for decades. There are now twice as many physicians per 100,000 population as there were when the AMA began tracking figures in the 1960s.

- **The number of physicians is increasing across the states.** Despite the cries of physicians fleeing multiple states, the number of physicians increased in every state in 2007. In addition, the increase in physicians either matched or outpaced population growth in every state over the last five years.

- **The ratio of doctors to population is higher in states WITHOUT caps.** The number of physicians per 100,000 population is 13 percent higher in states WITHOUT caps (319 v. 283).

**Physicians and Premiums**
Empirical research on the subject has found that physician supply is not connected to insurance premiums. Researchers at the National Bureau of Economic Research (NBER) for instance found that increases in medical negligence costs did not have an effect on the size of physician workforces, and concluded, “The arguments that state tort reforms will avert local physician shortages or lead to greater efficiencies in care
are not supported by our findings.”57 A study of Pennsylvania physicians by Mello and colleagues found that the number of physicians leaving their practices were similar both before and during the “malpractice crisis.”58 That finding came in contrast to the authors’ own survey of physicians. While 43 percent of high-risk specialists told the authors that they would restrict or eliminate services, only three percent actually did. Similarly, a comprehensive study of the number of OB/GYNs in the United States over a 10-year period conducted by researchers from Harvard, George Mason, and the University of Melbourne, Australia, found that there was no connection between supply of OB/GYNs and premiums or tort reforms. The authors concluded, “Our results suggest that most OB/GYNs do not respond to liability risk by relocating out of state or discontinuing their practice, and that tort reforms such as caps on noneconomic damages do not help states attract and retain high-risk specialists.”59

Data derived from Medical Liability Monitor’s annual rate survey shows that premiums in states with caps actually grew more over the period of the medical negligence crisis than states without caps.60 States without caps experienced a 77 percent increase in premiums, but states with caps experienced a 90 percent increase. States that enacted caps during this period saw even bigger premium increases of 129 percent. The average premium in states with caps was two percent higher than in states without caps.

**Physician Practice Expenses and Income**

One reason the empirical research has found no connection between physician supply and insurance premiums is that malpractice insurance premiums are not nearly as excessive as often portrayed. In fact, according to the AMA’s own data, medical malpractice premiums increased only slightly in the 30 years between 1970 and 2000. In the latter half of the period, premiums actually declined.61 In Massachusetts for instance, a state with one of the highest median medical negligence settlement payments and labeled a “crisis” state by the AMA, physicians actually paid less in inflation-adjusted premiums at the height of the crisis than they had 15 years earlier.62
Why then the call of a medical negligence crisis? The answer, at least in part, is that other expenses besides premiums increased while practice revenue declined.

Upon analyzing the issue, researchers at Suffolk University found medical negligence expenses were 11 percent of total practice expenses in 1986 as compared to 7 percent in 2000. Meanwhile, practice revenue also declined. From 1996 to 2000, physicians’ average income dropped nearly 10 percent ($254,229 in 1996 to $229,500 in 2000). The researchers concluded, “It was revenue decline and increases in nonpremium expenses, not premium increases, that account for the overwhelming share of falling income.” However, they went on to point out that even during this “crisis,” average physician income was still in the 95th-99th percentile of all Americans.

Defensive Medicine
Defensive medicine is the idea that doctors order unnecessary tests and medical procedures as a means to avoid medical negligence lawsuits. While proponents of tort reform argue that defensive medicine drives up the cost of health care, government researchers question whether defensive medicine truly exists. The Congressional Budget Office called the evidence of defensive medicine “not conclusive,” and summarized, “On the basis of existing studies and its own research, CBO believes that savings from reducing defensive medicine would be very small.” Researchers at Dartmouth College echoed these conclusions, saying, “The fact that we see very little evidence of widespread physician exodus or dramatic increases in the use of defensive medicine in response to increases in state malpractice premiums places the more dire predictions of malpractice alarmists in doubt.”

The Government Accountability Office (GAO) has issued similar statements questioning the occurrence of defensive medicine, saying, “the overall prevalence and costs of [defensive medicine] have not been reliably measured,” and “study results cannot be generalized to estimate the extent and cost of defensive medicine practices across the health care system.” The GAO reported that even “officials from AMA [American Medical Association] and several medical, hospital, and nursing home associations...told us that defensive medicine exists to some degree, but that it is difficult to measure.”

To the extent that defensive medicine does exist, research has found that the motivation behind it is not liability but rather a desire to simply help a patient or, in some cases, boost physician income. One government agency found that doctors chose not to order any tests or diagnostic procedures 95 percent of the time. Doctors who ordered tests almost always did so because of medical indications, and only one half of one percent of all cases involved doctors who ordered tests due solely to medical negligence concerns.

Doctors may actually practice “defensively” because it generates more income, according to the GAO. They identified “revenue-enhancing motives” as one of the real reasons behind the utilization of extra diagnostic tests and procedures. In Florida, health authorities determined diagnostic-imaging centers and clinical labs were ordering additional tests because the majority were physician-owned and the
tests provided a lucrative stream of income. Federal law now prohibits the referral of Medicare patients to certain physician-owned facilities, many of which charge double the amount in lab fees. As Mello and colleagues commented, “In medicine practiced as a business, defensive medicine is understood and may even be profitable.”

“So-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by the positive (albeit small) benefits to patients.”

Congressional Budget Office

Nor is defensive medicine necessarily bad medicine. The CBO, in its analysis, recognized that there was a financial incentive but also identified health benefits to patients: “so-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by the positive (albeit small) benefits to patients.” Researchers at Tulane University found similar benefits to patients. Their analysis of the National Practitioner Databank and the Nationwide Inpatient Sample (NIS) found that increased medical negligence risk was associated with an improvement in mortality, and concluded that the idea that defensive medicine had no positive effect on patients was untrue.
Why We Need the Civil Justice System

Medical Negligence “Reform”
While the political debate over medical negligence tends to focus on doctors’ insurance premiums or health care costs, one very important factor is often overlooked: the injured patients.

The injuries patients suffer from preventable medical errors are very real. Some are easily calculated, such as additional medical costs and lost wages, while others are less so, such as quality of life and pain and suffering. The problem with many medical negligence reforms is that they do not seek to prevent medical errors, but merely to shift the burden of these damages to the injured patients themselves.

Caps on non-economic damages are one such “reform” that do nothing to reform medical negligence at all. Non-economic damages compensate patients for very real injuries—such as the loss of a limb or sight, the loss of mobility, the loss of fertility, excruciating pain, or severe disfigurement, or even the loss of a child or a spouse. In the name of a “medical negligence crisis” many states have moved to cap these damages. The effect is often to render many medical negligence cases too expensive to bring to trial, especially for women, children, the elderly and the disabled—those who may not have suffered substantial economic loss. University of Buffalo law professor Lucinda Finley found that such groups received restitution far below average levels, and had a far harder time even getting to court because the expenses of a case often outweighed any potential award. She concluded, “caps benefit insurance companies by increasing their profits, while producing no benefit for doctors, and causing a detriment to injured people, especially women and the elderly.”

The “reform” takes away the restitution, but does nothing to prevent the injuries.

Civil Justice and Patient Safety
Such reforms also take away a powerful deterrent to medical negligence. The civil justice system not only provides patients with their constitutional right to seek restitution for their injuries in a court of law; it also encourages patient safety systems that help prevent negligence before it occurs. Hospitals, such as Connecticut’s Bridgeport Hospital, have reformed dangerous practices because of litigation. In some cases, entire medical fields have been transformed.

In the 1970s, anesthesiology was one of the highest risk medical specialties. In order to improve patient safety and reduce doctors’ medical negligence costs, the American Society of Anesthesiologists created the

The Bridgeport Hospital Experience
In the late 1990’s, hospital administrators at Bridgeport Hospital in Bridgeport, Connecticut, were aware of a rash of infections caused by unsanitary conditions. Attempts to identify possible causes and solutions were ignored, partly for financial reasons. Eventually the staph outbreak resulted in a series of deaths. Lawsuits filed as a result uncovered a range of dangerous practices in the hospital, such as doctors not washing their hands before surgery and wearing non-sterile clothes in the operating room.

As a result, Bridgeport Hospital embarked on a $30 million renovation. The hospital upgraded its air filtration system and hand washing stations, and made changes to staff practices, such as a prohibition on doctors wearing scrubs home. These improvements drastically cut infection rates, from 22 percent of cardiac surgery patients to nearly zero.
Closed Claims Project to analyze data from lawsuits. Researchers were able to identify system failures and implement comprehensive practice changes. The results yielded a dramatic improvement in patient safety, and in the process anesthesiologists drastically lowered their inflation-adjusted malpractice insurance premiums.

### Analysis of Anesthesiologists’ Claims Data

<table>
<thead>
<tr>
<th>BEFORE THE CLOSED CLAIM PROJECT</th>
<th>AFTER THE CLOSED CLAIM PROJECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 in 10,000 people who went under anesthesia died from the procedure.</td>
<td>1 in 200,000 people who went under anesthesia died from the procedure.</td>
</tr>
<tr>
<td>Anesthesiologists were responsible for 7.9 percent of all negligence claims.</td>
<td>Anesthesiologists were responsible for 3.8 percent of all negligence claims.</td>
</tr>
<tr>
<td>The average malpractice premium for anesthesiologists was $18,000 in 1985.</td>
<td>The average malpractice premium for anesthesiologists was $18,000 in 2002. Adjusted for inflation, the average anesthesiologist’s malpractice premium dropped between 1985 and 2002.</td>
</tr>
</tbody>
</table>

**More Tort Reform Equals Worse Health Care**

Medical negligence lawsuits serve an important role in promoting public health and patient safety. Evidence suggests that the lessening of accountability that comes from reforms such as medical negligence caps can have a detrimental effect on patient safety and health care quality. A study from the American College of Emergency Physicians found that safety improves when injured patients can hold negligent hospitals or physicians accountable. States with aggressive legislation limiting patient access to the legal system are also the states that score lowest in patient safety. Overall, the 10 states doctors claim have the “best liability environment” (more tort reform) have a D+ score for patient safety (just two points above fail). In contrast, the 10 states doctors claim have the “worst liability environment” have a B- for patient safety, above the C+ national average. The 25 states with “best liability environments” all rank below the national average for patient safety.

Similarly, data collected from the non-partisan Commonwealth Fund show health care in states that cap damages in medical negligence cases tends to be of lower quality than health care in states that do not. Patients in states that do not cap damages have better access to health care and are more likely to be covered by health insurance than patients living in states with caps on damages. The aforementioned study from Tulane University also found that states with more accountability experienced lower rates of mortality. Analysis by Professors David Hyman and Charles Silver also found that insulating providers from liability was detrimental to patient safety, and concluded, “The widely held belief that fear of malpractice liability impedes efforts to improve the reliability of health care delivery systems is unfounded.”

Professors Jonathan Klick and Thomas Stratmann similarly...
noted medical negligence reforms resulted in lower health care quality and increased infant mortality.\textsuperscript{85}

**Weeding Out Dangerous Doctors**

Alternative compensation systems, such as health courts, propose eliminating or greatly sidelining procedures for disciplining doctors in the hope of fostering more candor over doctors’ mistakes. However, every profession has its share of bad apples, and health care is no exception. Bad apples such as Dr. Robert Ricketson. Ricketson moved from state to state, leaving a raft of seriously injured patients in his wake, before settling in Hawaii in 1998. He never told the Hawaii authorities about his disciplinary record or addiction to narcotics. The next year during a spinal surgery, Ricketson found that the titanium rods he intended to implant in patient Arturo Iturralde’s spine were missing. Rather than wait 45 minutes for the rods to be delivered, Ricketson cut up a stainless steel screwdriver and used the pieces to brace the spine. Days later, the screwdriver broke. Iturralde was rendered paraplegic and died two years later.

National Practitioner Data Bank (NPDB) data indicate just six percent of doctors are responsible for 58 percent of all negligence incidents.\textsuperscript{86} The civil justice system seeks to weed out those few doctors whose actions have such devastating impact on patients.

The civil justice system is necessary because other disciplinary mechanisms are woefully inadequate. State medical boards, for instance, are supposed to discipline doctors who consistently violate standards of care. Yet less than nine percent of doctors who make multiple malpractice payments are ever subject to medical board discipline. Two-thirds of doctors who make 10 or more malpractice payments are never disciplined at all. Doctors like Dr. Eric Scheffey, a Texas orthopedic surgeon who earned the nickname “Eric the Red” during a two decade career that left hundreds of patients dead or maimed. Scheffey lost his privileges at three different hospitals and admitted abusing cocaine for 18 months. Yet even after a judge recommended his license be taken away, the Texas Board of Medical Examiners allowed him to continue practicing. In 2005, after 24 years in practice and more than 78 medical negligence lawsuits, the board revoked his license.

Nor are hospitals stepping up to protect their patients. Though they are on the front line of patient safety and are required to review medical care through peer review and other processes, 49 percent of U.S. hospitals have never reported a single disciplinary action against one of their doctors since the National Practitioner Databank was created in 1990.\textsuperscript{87}
Conclusion

Preventable medical errors kill and seriously injure hundreds of thousands of Americans every year. Only heart disease and cancer kill more Americans. Yet despite this, much of the medical negligence policy debate has revolved around indirect factors, such as doctors’ insurance premiums. Any discussion of medical negligence that does not involve preventable medical errors ignores the fundamental problem. Preventing medical errors will dramatically lower health care costs, reduce doctors’ insurance premiums, and protect the health and well-being of patients.

The accountability promoted by the civil justice system is the engine of patient safety. No other mechanism or proposed alternative encourages accountability as effectively as the civil justice system. Rather than seeking to undermine this accountability, we must bolster it. For in fostering accountability lies the key to both increased patient safety and lower health care costs. Without the civil justice system, patient safety will suffer and health care costs will go up for everyone.

1 To Err Is Human: Building a Safer Health System, Institute of Medicine, 1999
7 Press Release, RAND Corporation, RAND Study Says Computerizing Medical Records Could Save $81 Billion Annually and Improve the Quality of Medical Care, September 14, 2005.
8 To Err is Human: Building a Safer Health System, Institute of Medicine, 1999; Preventing Medication Errors, Report Brief, Institute of Medicine, July 2006.
11 Ibid.
13 Ibid.
14 Centers for Disease Control and Prevention as viewed in Robert Langreth, Fixing Hospitals, Forbes, June 20, 2005.
15 Ibid.
Medical Negligence: A Primer for the Nation’s Health Care Debate


19 Ronald Lee Nichols, Preventing Surgical Site Infections: A Surgeon’s Perspective, Emerging Infectious Diseases, Centers for Disease Control and Prevention, March/April 2001.


22 Robert Langreth, supra note 14.


26 Those medical complications not covered were: Object Left in Surgery (Serious Preventable Event); Air Embolism (Serious Preventable Event); Blood Incompatibility (Serious Preventable Event); Catheter-Associated Urinary Tract Infections Pressure Ulcers (Decubitus Ulcers); Vascular Catheter-Associated Infection Surgical Site Infection Hospital Acquired Injuries, including fractures, dislocations, intracranial injury, crushing injury, and burns. See 72 F.R. 47201.

27 72 F.R. 47201.


37 NPDB, supra note 33.


43 IOM, supra note 1.
47 Limiting Tort Liability for Medical Malpractice, Congressional Budget Office, January 8, 2004; for the purposes of the chart, Personal Health Care Expenditures is taken from the Centers of Medicare and Medicaid Services and is $1.88 trillion (http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf - tables 1 & 2), and total spent on medical malpractice insurance is Tillinghast Towers Perrin (2008 Update on U.S. Tort Cost Trends, Tillinghast Towers Perrin, 2008); The CBO has reaffirmed its earlier findings that tort reform does not lower health care costs. In 2008, the agency found that “the effect [of tort limits] would be relatively small—less than 0.5 percent of total health care spending.”- Budget Options Volume I Health Care, Congressional Budget Office, December 2008.
50 Americans for Insurance Reform, supra note 39.
54 Cathy Takarski, Medical Error-Prevention Strategies Face Barriers to Acceptance, Medscape Money and Medicine, 2000.
55 Hilary Rodham Clinton, Barack Obama, supra note 46.
57 Katherine Baicker and Amitabh Chandra, supra note 49.
60 Derived from data provided by Medical Liability Monitor (Oct 2001 & Oct 2008). A state’s average premium is calculated as the unweighted mean value of premiums for all companies for which data is provided across all regions. A state is classified as having a cap when the state has enacted either a general non-economic damage cap that affects medical malpractice cases or a medical malpractice specific cap on non-economic and/or compensatory damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not
counted since these represent a small number of cases. Note: several states switched categories during this period and were thus excluded from the analysis. From a research design perspective it is imperative that variables maintain consistency over time. Premiums represent the average of internal medicine, general surgery and OB/Gyn rates.


66 Katherine Baicker and Amitabh Chandra, supra note 49.

67 GAO, supra note 56.

68 Ibid.


70 GAO, supra note 56.


77 Ibid.


79 Ibid.

80 Ibid.

81 Ibid.


83 Praveen Dhankhar, M. Mahmud Khan, Shalini Bagga, supra note 74.


NPDB supra, note 33, table 15.