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**Medical Malpractice**

## THE REAL FACTS ABOUT MEDICAL MALPRACTICE

- Critical States' Rights are in Jeopardy. Reducing the federal bureaucracy and restoring states' rights to legislate on a wide range of issues without federal intervention are central goals of the 104th Congress. Federalizing medical malpractice laws that have traditionally been within the exclusive domain of state legislatures runs directly counter to such goals and sends a disturbing "Washington Knows Best" message.
- The Costs of Medical Malpractice Liability Claims Amount To Less Than One Percent Of Total Health Care Costs. So Even a Total Elimination of All Tort Claims Would Not Significantly Reduce U.S. Health Care Costs. (U.S. Dept. of H.H.S., CBO and Office of Tech. Assessment). Liability insurance coverage is less than three percent of the typical doctor's income. To the extent that liability insurance costs are higher, this is the result of insurance company practices that could be easily addressed through insurance reform.
- Experiences at the State Level Prove that Malpractice "Reform" has No Affect on Health Care Expenditures or Liability Insurance Premiums. California's MICRA law has failed to reduce health care or liability insurance costs. (GAO, Proposition 103 Enforcement Project Study). Similarly, damage caps have not reduced health care costs in Alaska, Colorado, Hawaii, Maryland, Michigan, Missouri or Utah. (Coalition for Consumer Rights).
- "Defensive Medicine" Is A Red Herring. For years, proponents of draconian medical malpractice "reforms" have made unsubstantiated claims about "defensive medicine". However, the results of a 1994 landmark study by the Office of Technology Assessment on "defensive medicine" completely undermine the credibility of these claims. The OTA found that: (1) the widely-cited Lewin-VHI study "is not a reliable gauge of the possible range of defensive medicine costs"; (2) only "a relatively small proportion of all diagnostic procedures. . . is likely to be caused primarily by conscious concern about malpractice liability risk"; (3) the effect of tort reform on defensive medicine costs is "likely to be small"; and (4) defensive medicine may "benefit patients" by producing safer medical care.
- The Problem With Medical Negligence Is Medical Negligence. Every year, medical negligence injures or kills hundreds of thousands of Americans. (Harvard Medical Malpractice Study). In fact, more people are killed by medical negligence a year than perish due to automobile accidents, airplane crashes, and drug overdoses combined. (Nat'l Safety Council, Nat'l Transportation Safety Board; Nat'l Center for Health Statistics). We have strict seatbelt and drunk driving laws to improve highway safety, tough FAA oversight to ensure safe air travel, and comprehensive anti-drug programs to reduce substance abuse. Why is it then that Congress is now considering medical malpractice "reforms" that would decrease incentives for the safest possible practice of medicine?
- Malpractice Awards Are Small and Unbiased. Inappropriate and unjustified malpractice awards are "uncommon", and awards are directly tied to the degree of physician negligence -- not to the degree of patient injury. (American College of Physicians).

## NONECONOMIC DAMAGE CAPS ARE UNNECESSARY AND UNFAIR

- Despite questionable anecdotal evidence of uncontrolled jury verdicts, the hard facts show that malpractice awards are rarely excessive. One recent study by Duke University found a median malpractice award of only \$36,500 in North Carolina. (Atlanta Const., 2/1/93).
- Experience at the state level suggests that damage caps have virtually no impact on health care costs or doctor's insurance premiums. A recent study of eight states with damage caps (AK, CO, HI, MD, MA, MI, MO, and UT) found that caps had no effect on health care or liability insurance costs. (Coalition for Consumer Rights, 1/95). Indiana's \$750,000 cap on total damages and California's \$250,000 cap on noneconomic damages have also failed to reduce health care costs. (GAO, 2/92; Families USA Foundation, 1990). Even the AMA has conceded that there are "no definitive studies" verifying that California's damage cap has reduced costs. (BNA's Health Law Reporter, 4/6/95). It is verifiable, however, that malpractice premiums in California increased by 190% during the 12-years following enactment of a cap in 1975. (Proposition 103 Enforcement Project Study, 1995).
- Despite having no impact on health care or insurance costs, damage caps do have a tremendously negative impact on the permanently or catastrophically injured who are most in need of financial protection. Even the AMA has testified that caps effect only those cases involving severe injury where the victim faces the greatest need for compensation. When damage caps leave such victims unable to meet the costs associated with their injuries, the government is often left footing the bill with taxpayer dollars. It is simply bad public policy for the government to bear such costs rather than negligent defendants.
- Noneconomic damage caps also discriminate against women, minorities, the poor, the young, the elderly, the unemployed and other patients who often cannot show substantial economic loss (*i.e.*, lost wages).
- An arbitrary and inflexible damage cap is inconsistent with the completely unpredictable nature of injuries that may be caused by medical negligence. Fairly compensating victims of medical negligence is not like baking a cake where a strict "recipe" can be applied to all situations. Rather, each case must be judged on its own unique circumstances.
- It is untrue that noneconomic damages are simply a way for juries to justify large awards to plaintiffs. Although they may be harder to quantify and evaluate than economic damages, noneconomic damages compensate victims of malpractice for real loss and suffering (*i.e.*, loss of sight, disfigurement, the inability to bear children, the loss of a limb, *etc.*).
- Damage caps may actually "increase the probability of a patient suffering" from malpractice by removing the deterrent threat of a large award. (W. Virg. Law Rev., 1991).
- Damage caps create two classes of defendants in society -- doctors and everyone else. Assume a patient is paralyzed by a surgeon's negligence in California and then an hour later the surgeon is paralyzed after being struck by a speeding car driven by the patient's wife. The patient suing the surgeon could recover only \$250,000 in noneconomic damages, yet the surgeon suing the patient's wife could recover an unlimited amount.



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LOS ANGELES TIMES MONDAY, JANUARY 29, 1996 A3

# Controversy Grows Over California Malpractice Cap

■ **Courts:** Doctors seek U.S. version of state's \$250,000 limit for pain and suffering. But consumers, lawyers assail 20-year-old law.

By DOUGLAS P. SHUIT  
TIMES STAFF WRITER

Kathy Olsen won her medical malpractice suit but ended up feeling like a loser. Last year, a San Diego jury found that medical negligence was involved in the care given to her son Steven, now 5, care that left him blind and permanently disabled with severe brain damage. In addition to awarding \$4.3 million for past and future medical bills, the jury handed down a verdict of \$7 million for "pain and suffering." But because of a \$250,000 California cap on malpractice

awards for pain and suffering, the trial judge reduced the award to that figure, much of which went to pay legal fees. Olsen, now awaiting the outcome of an appeal of the verdict by the University of California Board of Regents, said she is frustrated by the state's malpractice law. "The law didn't work for us," she said. She is not the only one who feels that way. Twenty years after the landmark law putting a monetary "hard cap" on general damages for medical negligence took effect, the state's malpractice system is more controversial than ever. In recent months, Californians angry

with the malpractice system have demonstrated in wheelchairs and on crutches, dumped manure at a congressman's office, testified against organized medicine at legislative hearings in Sacramento and stuffed photos and case histories into a coffin and delivered them to a senator's office. California's malpractice law also has been pushed to center stage in the national debate over medical negligence. Last year, federal legislation containing a California-type cap was approved by the House of Representatives but was defeated in the Senate. Its chief proponent, the American Medical Assn., said it will try to revive the legislation this year. A similar cap remains part of the Republican "Contract with America," the GOP legislative battle plan.

At the core of the controversy is the California Medical Injury Compensation Reform Act, or MICRA. Written at the height of a malpractice insurance crisis in the mid-1970s, when premiums were shooting out of sight and doctors were turning away patients, MICRA was devised in large part to protect doctors and hospitals from big jury awards. Although the law also sharply limits attorney's fees in malpractice cases, most of the controversy stems from the \$250,000 cap on general damages, the provision that required the judge in the Olsen case to erase the \$7-million jury award. Juries can be told at judges' discretion about the cap but often are not. General damages, widely known as **Please see CAP, A15**

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# CAP: State's Landmark Malpractice Limit Is Assailed

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 compensation for pain and suffering, are a catchall category that includes the day-to-day physical and emotional problems that a boy such as Steven Olsen most likely will face now and later in life.

Critics point out that payments for attorneys, court costs and things such as fees for expert witnesses are included within the \$250,000 cap. Moreover, they say the cap is not indexed for inflation, and the purchasing power of \$250,000 is about a third of what it was two decades ago.

Because general damages are so subjective, they are far more controversial than payouts for economic damages, which may be used solely for future medical costs and loss of earnings.

Doctors and insurance companies say hard caps on pain and suffering and attorney's fees are the fairest and sanest way to limit potentially runaway malpractice awards. There are no limits on damages for medical bills and loss of income directly related to patient injuries, if they can be proven, MICRA supporters say.

They also argue that \$250,000 is fair compensation for pain and suffering.

"You can never make a person whole, even if you shower them with money," said Jay Dec Michael, president of Californians Allied for Patient Protection, an association of doctors, hospitals and insurance organizations to defend the malpractice law. "Our goal is to make sure they get adequate compensation for economic loss."

But patients complain that they can't find a lawyer to take their cases because attorneys tell them that only the most egregious cases make money.

One who did find a lawyer is Rosemary Green. The Florida woman's husband died after his lungs were accidentally switched during a transplant operation at UCLA Medical Center. She said she was warned to expect an emotionally draining fight when she filed suit against the university a year ago.

"As time goes on, you feel like the system jerks you around," she said. "I just get angrier."

"The rage this kind of thing engenders is unfathomable until you have lived through it," said Linda D. Ross, a Los Angeles businesswoman turned malpractice activist.

Ross won an arbitration award of \$150,000 from Kaiser Permanente

in a case that involved the death of her mother. Convinced that her mother's death could have been avoided, Ross had hoped to win a financial judgment large enough to force a change in the procedures that she said contributed to her mother's death. But Ross said she quickly ran up against the pressure of the cap and decided to settle. Still, she continues her fight to change the law by testifying at government hearings, contending that the award was little more than "a slap on the wrist" for Kaiser.

Kaiser concedes that it erred, but Trischa O'Hanlon, a senior attorney for Kaiser Permanente, calls the judgment more than a slap on the wrist. The settlement, she says, triggered an upgrading of training at the Kaiser Foundation Hospital in Fontana, where Ross' mother was treated, as well as new procedures imposed to ensure that physicians see needy patients in a timely fashion in the wake of the Ross case, she said.

"This law is an absolute, unmitigated disaster," said San Francisco attorney Robert V. Bokelman. The malpractice specialist said it costs him \$100,000 to bring a major malpractice case, which can involve years of litigation, sometimes furnishing expert witnesses, and a team of lawyers and researchers. "We have to be extremely selective in the cases we take. I get, on the average, five telephone calls a day, and we accept only five to 10 cases a year."

Before MICRA, attorneys sought fees of 30% to 40% on damage awards, as they still are allowed to do in other personal injury suits. Under MICRA, the attorneys can receive a maximum of 15% on awards of more than \$200,000.

"I probably take one out of every 30 or 40 cases referred to me," said Woodland Hills attorney Chuck Mazurek. "I really would like to take every case that comes to me that is meritorious, but because of the expense involved and the limited recovery, I have to make an economic decision."

Harvey Rosenfield, a consumer activist who has written a book about the malpractice system, said the cap has produced a profit bonanza for the insurance industry.

During 1990, California malpractice insurance companies, some of them owned by doctors, paid out only 36 cents for every \$1 in premiums that they took in, Rosenfield said.

So many people claim to be victims of California's malpractice law that a Los Angeles consumer

group, Consumers for Quality Care, began a "casualty of the day" campaign in April that involved releasing a case study each workday that detailed a medical mistake and a person's unhappy brush with the legal system.

The campaign lasted until August, stopping only when the AMA-backed federal legislation failed.

For Kathy Olsen, the law has been a constant irritant, repeatedly rubbing raw the emotional wounds resulting from her son's plight.

Steven, then 2, fell during a family hike. A twig went through his mouth and out his cheek, creating an infection that eventually went to his brain.

Olsen, 39, said she pleaded with the staff at Children's Hospital in San Diego for a CT scan of her son's brain. They refused, and by the time he was tested and doctors discovered the problem, it was too late to prevent permanent brain damage, she argued in her successful suit.

The hospital was not named in the suit. Attorneys for a medical group named in the original suit have settled with her. The University of California Board of Regents, which employed one of the physicians who diagnosed Steven, is appealing the judgment. The university contends that its physician exercised a reasonable standard of care.

Today her son's medical problems sharply limit his ability to walk, learn and socialize with other children.

While \$4.3 million is a lot, Michael D. Padilla, the San Diego attorney who handled the case for the Olsens, said payments will be spread out over 60 years.

"Steven is going to need every dime of that money if he lives 60 years," Padilla said. "There will be doctors' bills, nursing care, modifications to homes he will live in. That is all based on economists' projections of what medical costs will be 50 years from now. We have to just hope they are right."

Rosemary Green, on behalf of her husband, is filing a malpractice suit that is well above the \$250,000 cap. She said she was motivated in part by a desire "to have someone learn from this."

Her husband Frank was suffering from end-stage lung disease when he left his family home in Florida for the transplants that he hoped would change his life.

But his surgeons, by their own

admission, "mistakenly" switched Frank Green's new lungs. The left donor lung was put into his right chest cavity. Doctors then said they tried to "salvage the situation as best we could" and sewed Green up with the right lung where the left one should have been, according to a medical review of the case.

He died nine days later. Internal UCLA documents obtained by The Times concede that a mistake was made, but UCLA has denied negligence in its response to the suit and refuses to comment on the case.

"It's such a long, tedious process," said Green, 48, who lives in West Palm Beach. "It's not the money; it's the justice. I want them to own up to what they did and learn from it."

## **CALIFORNIA'S MICRA: THE UNFULFILLED PROMISE OF MALPRACTICE LIABILITY REFORM**

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In 1975, the California legislature passed one of the nation's most comprehensive medical malpractice reform laws: the "Medical Injury Compensation Reform Act", or "MICRA". The essential provisions of MICRA are: (1) a \$250,000 cap on noneconomic damages; (2) allowing damage awards of over \$50,000 to be paid in periodic installments; (3) permitting the defense to inform the jury about any other sources of compensation available to the plaintiff ("collateral sources"); and (4) establishing a sliding scale for attorneys' contingency fees.

Physician and insurance groups that aggressively lobbied for MICRA promised that placing these unprecedented restrictions on the rights of negligently injured patients to recover compensation would solve California's fundamental health care problems. However, California's experience under MICRA over the last twenty years demonstrates that these promises were empty. Health care costs and liability insurance premiums have continued their rising course in the years since MICRA's enactment. This failure by MICRA to deliver reduced health care or liability insurance costs is supported by a growing body of independent research.

MICRA has also created new problems of its own. MICRA has acted to discriminate against those who can least afford the burden: women, minorities, the poor, the elderly, the very young, and the seriously injured. Under MICRA, these victims of malpractice have little chance of obtaining the representation they need to obtain fair compensation for their injuries. Moreover, MICRA's enactment has coincided with an increase in the rate of medical malpractice in California -- adding health care expenses itself -- by eliminating incentives for the safest possible medical care.

### **I. INDEPENDENT RESEARCH PROVIDES STRONG EVIDENCE THAT MICRA HAS NOT REDUCED CALIFORNIA'S HEALTH CARE OR LIABILITY INSURANCE COSTS AS PROMISED.**

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The most comprehensive study on MICRA's impact to date was conducted by a California citizen organization called the Proposition 103 Enforcement Project.<sup>12</sup> This group speculated that if the "advocates of tort law restrictions are correct, health care costs in California should have dropped after MICRA's passage and should have remained below the national average [per capita] since then."<sup>22</sup> However, the evidence collected by this study paints a different picture:

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<sup>12</sup> Proposition 103 Enforcement Project, *MICRA: The Impact on Health Care Costs of California's Experiment With Restrictions on Medical Malpractice Lawsuits*, 1995.

<sup>22</sup> *Id.*

- California's health care costs have continued to skyrocket at a rate faster than inflation since the passage of MICRA -- and in recent years that growth rate has accelerated. Inflation as measured by the Consumer Price Index rose 186% between 1975 and 1993, yet California's health care costs grew by 343% during the same period. Moreover, California's health care costs have grown at almost twice the rate of inflation since 1985.
- California's health care costs have grown at a higher rate than the national average since MICRA's enactment in 1975 (8.6% vs. 8.4%, respectively).
- Per capital health care expenditures in California have exceeded the national average every year between 1975 and 1993 by an average of 9% per year.
- California's medical malpractice liability premiums actually *increased* by 190% in the twelve years (1976-1988) following enactment of MICRA.
- Any moderation of liability insurance premiums since 1988 is the result of "dramatic changes" in the insurance industry that are unrelated to MICRA. Such changes include: (1) the approval by California voters in 1988 of a ballot measure, known as Proposition 103, which required a 20% decrease in premium rates for medical malpractice liability insurance and prohibited any subsequent rate increase without prior approval by the insurance commissioner; (2) a tremendous increase in the number of non-profit, doctor/hospital-owned insurance carriers that are capable of offering much lower rates than private, for-profit insurers; and (3) the insurance industry started to rebound financially from bad investments and plummeting interest rates of earlier years.
- Hospital patient costs are higher in California than in other major states. Comparing hospital patient costs in the ten most densely populated states between 1985 and 1993, California's were the highest in four years (1985, 1989, 1992, and 1993) and second highest in the other two years (1988 and 1990).
- According to the most typical indicators (*e.g.* the number of Cesarean-section births), MICRA has not reduced so-called "defensive" medicine in California.<sup>31</sup>

These findings are consistent with research conducted by the General Accounting Office of the United States Congress (GAO). A 1992 GAO study on health care spending at the state level found that per capita health care expenditures in California were second highest in the nation in both 1982 and 1990 and were considerably higher than the national average in those years (18.9% higher in 1982 and 19.3% higher in 1990) despite MICRA.<sup>32</sup> Moreover, a 1986 GAO study found that liability insurance premiums in California continued to rise sharply after MICRA's passage.<sup>33</sup> In fact, liability insurance rates increased by a median of 99% for southern California physicians from 1980 to 1986.<sup>34</sup>

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<sup>31</sup> Id.

<sup>32</sup> General Accounting Office, *Health Care Spending: Nonpolicy Factors Account for Most State Differences*, GAO/HRD 92-36, February 1992.

<sup>33</sup> General Accounting Office, *Medical Malpractice: Six States Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms*, GAO/HRD-87-21, December 1986.

<sup>34</sup> Id.

## **II. MICRA HAS EXACERBATED CALIFORNIA'S HEALTH CARE CRISIS BY CREATING SEVERE NEW PROBLEMS FOR PATIENTS.**

Not only has MICRA failed to solve any of the major problems facing the California health care system, but it has created a new California health care "crisis" by creating severe problems for patients and consumers.

### **A. MICRA's Limits on Noneconomic Damages and Attorneys' Contingency Fees Have Left Medical Malpractice Victims Undercompensated.**

MICRA's "one-size-fits-all" \$250,000 cap on noneconomic damages has left patients victimized by medical malpractice grossly undercompensated. Although they may be harder to quantify and evaluate than economic damages (*i.e.*, lost wages), noneconomic damages compensate victims of malpractice for real loss. Injuries resulting in loss of sight, disfigurement, the inability to bear children, or the loss of a limb, for example, often cannot be measured in terms of lost wages or other economic calculations, but such injuries lead to genuine suffering for which the victim should be compensated. Unfortunately, inflation has devalued MICRA's noneconomic damages cap to a little more than \$100,000. This amount is obviously insufficient to compensate the most seriously and catastrophically injured malpractice victims. In addition, MICRA's cap has discriminated against women, minorities, the poor, children, the elderly, the unemployed and other patients who statistically have a lower showing of economic loss.

In essence, MICRA has created two classes of defendants in society -- doctors and everyone else. Consider a hypothetical: a patient visits a physician for a routine examination. While on the examination table the patient is given an incorrect injection which causes seizure and patient falls off the examining table and fractures a cervical vertebrae, resulting in permanent quadriplegia. The doctor, leaving the office, is struck by an automobile driven by the injured patient's wife who is rushing to the hospital. The collision causes a fracture of one of the doctor's cervical vertebrae, also causing permanent quadriplegia. Under MICRA, the quadriplegic patient, suing the physician, can only recover \$250,000 in noneconomic damages, while the quadriplegic physician, suing the patient's wife, may recover noneconomic loss without limitation.

To demonstrate the discriminatory and unfair impact that MICRA has had on the victims of medical malpractice in California, consider these tragic real-life stories:

- ♦ A Southern California gynecologist named Dr. Ivan Namihas committed repeated acts of sexual abuse on almost 200 women, including sexual touching, pelvic exams without gloves, and falsely telling patients they had AIDS. However, none of these women could find an attorney financially able to file a malpractice suit against Namihas because the damages caused by his acts were noneconomic in nature and therefore severely capped by MICRA.

- ♦ Five-year old Steven Olsen is now blind, severely brain damaged and physically crippled after San Diego doctors negligently misdiagnosed his brain injury and refused to give him a CT-scan that could have prevented permanent damage (no "defensive medicine" here!) Despite having to endure a lifetime of suffering and medical treatment, Steven's \$6,750,000 noneconomic damages award was reduced to \$250,000 by MICRA.
- ♦ Thirty-year old Gretchen Yearous checked into a San Diego hospital for simple surgery to correct a uterine condition, yet her life was tragically altered when the surgeon negligently punctured her colon and heart. It took nine surgeries and three emergency life saving procedures to repair the damage from the botched surgery. Despite obtaining affidavits from several doctors confirming malpractice, Gretchen has been denied compensation because MICRA's recovery limits made her case financially unfeasible for attorneys other than those paid on an hourly basis, which she could not afford. Gretchen is now alone, in constant pain, unable to work, and has had to turn to taxpayer funded public assistance to pay for her care and living expenses.
- ♦ Oakland's Tomita Shimato was horribly scarred and disfigured during a routine mastectomy by a Bay Area surgeon who abused cocaine and Demerol. Although she endured nine corrective surgeries to remove the damage inflicted by this drug-using physician, Tomita has been left uncompensated and unable to find legal representation due to MICRA's caps on noneconomic damages and attorneys' fees.
- ♦ Surgeons at a Long Beach hospital negligently removed Harry Jordan's healthy kidney and left his cancerous kidney behind. As a result, Harry had to spend the rest of his life in pain, unable to walk, and dependent on a dialysis machine. The jury's verdict of \$5 million was cut by MICRA to \$250,000 -- less than his court costs and attorney's fees.

#### **B. MICRA's Restrictions on Patients' Rights Have Reduced the Level of Deterrence Against Medical Malpractice in California.**

Besides hindering the ability of malpractice victims to receive fair compensation, MICRA's severe restrictions on patients rights also have coincided with an increase in the level of medical malpractice in California. According to data collected by the National Practitioner Data Bank, a nationwide repository for medical malpractice information, the rate of malpractice in California has increased by almost 45% since 1991.<sup>21</sup>

Patient injuries stemming from medical malpractice add significant costs to California's health care system in the form of prolonged hospital stays, additional medications and procedures, and other drainage of health care resources. Thus, enacting MICRA-type measures at the federal level could potentially increase national health care costs by reducing incentives for the safest possible medical care.

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<sup>21</sup> U.S. Dept. of Health and Human Services, *National Practitioner Data Bank 1994 Annual Report*, 1995.

### III. CONCLUSION

The California legislature was mistakenly persuaded in 1975 that limiting the rights of medical malpractice victims would reduce California's health care and liability insurance costs. These same misguided and unsubstantiated claims are being made at the federal level today as MICRA is touted as a model medical malpractice statute. This time, however, Congress can look to California's twenty year failed experiment with MICRA as evidence that medical malpractice reform is simply not an appropriate way to reduce federal health care costs, insurance premiums, or "defensive" medicine.

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# MEDICAL MALPRACTICE LIABILITY REFORM WILL NOT AFFECT FEDERAL HEALTH CARE EXPENDITURES

July 31, 1995

Physicians, hospital organizations, and health insurers routinely promise that federal medical malpractice liability reform will reduce national health care expenditures by curbing liability insurance premiums and so-called "defensive" medicine. This message has been so pervasively delivered to lawmakers and the media that its validity is almost assumed. However, no verifiable evidence has been presented to support a link between medical malpractice reform and reduced federal health care costs. In fact, liability reform may actually *increase* costs by eliminating incentives for the safest possible medical care, which reduces costly injuries.

## **I. The Congressional Budget Office Estimates that Medical Malpractice Reform Will Not Lead to Any Reduction in National Health Care Spending**

The Congressional Budget Office ("CBO") has been asked several times by Congress to project the anticipated budgetary effects of various health care reform proposals. These CBO projections have repeatedly concluded that medical malpractice reform will not result in any significant reduction in national health care expenditures or costs.

For example, the CBO's projections regarding the impact of the Clinton Administration's health care reform proposal in the 103rd Congress came to the following conclusions about the cost-savings potential of medical malpractice reform:

The available evidence on the costs of malpractice insurance indicates that, while changes in the medical liability system could effect both total spending for malpractice premiums and the distribution of those premiums, the impact on national health expenditures would be small. Malpractice premiums in 1990 totaled only \$5 billion, or 0.74 percent of national health expenditures.

The existing evidence on the prevalence and costs of defensive medicine suggests that the potential to achieve savings is limited in this area, as well. The Office of Technology Assessment is conducting a study of this issue that may provide more information about the effect of defensive medicine on health care costs. At this time, however, there is little evidence to support an assumption that national health care spending would be significantly reduced by modifying the medical malpractice system. If the system were changed, much of the care that is perceived as defensive medicine would possibly still be provided for other reasons, such as reducing diagnostic uncertainty as much as possible.<sup>1</sup>

The CBO's projections regarding the budgetary impact of various health care proposals from the 102nd Congress similarly dispelled claims regarding the link between malpractice reform and reduced federal health care spending:

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<sup>1</sup> CBO TESTIMONY: Statement of Robert D. Reischauer Before the Committee on Ways and Means of the U.S. House of Representatives, March 4, 1992.

According to the available evidence, changes in the medical malpractice liability system could affect both total spending for malpractice premiums and the distribution of those premiums, but the impact on national health expenditures would be small. . . . The existing evidence on the prevalence and costs of defensive medicine suggests that the potential to achieve savings is limited in this area, too. If the malpractice system were changed, much of the care that is perceived as defensive medicine would probably still be provided for other reasons, such as reducing diagnostic uncertainty. *Therefore, the estimates in this paper assume no reduction in national health care expenditures as a result of the proposed reforms in malpractice insurance.* (emphasis added).<sup>2</sup>

The CBO has also recognized that medical malpractice reform could actually raise national health care expenditures by increasing the risk of medical injuries stemming from negligence:

The current tort liability system may deter some medical injuries, thereby tending to lower spending on health care. If so, changing the system could raise national health expenditures and other costs associated with medical injury, including reduced earnings. The basis for this argument is that tort liability reduces costs insofar as it deters medical accidents. . . . [A study by Patricia] Danzon has inferred from available data that the economic costs of medical injuries may be 10 times greater than total malpractice premiums, which would imply costs of about \$50 billion in 1990. Given this, she notes, the tort liability system could justify its costs if it deterred even a relatively small proportion of medical injuries.<sup>3</sup>

## **II. The Office of Technology Assessment Concurs That Malpractice Reform Will Have No Significant Impact on Health Care Expenditures or Defensive Medicine**

The Office of Technology Assessment ("OTA") recently conducted two comprehensive studies on the medical malpractice issue and its findings are remarkably consistent with those of the CBO.

The first major study by OTA<sup>4</sup> calculated that the \$4.86 billion spent on malpractice liability premiums in 1991 accounted for only 0.66% of total U.S. health care expenditures during the same year. Because this figure is so minuscule in relation to other factors influencing health care costs, the OTA concluded that medical malpractice reform would not directly result in any significant reduction to the national health care budget. The OTA stressed that "[m]edical malpractice reform can be expected to generate savings in overall health care costs only if it can be shown that physicians order a significant number of extra tests and procedures and that these defensive practices are indeed influenced by the level of malpractice claim activity."<sup>5</sup>

Having determined in its first study that medical malpractice reform would not result in substantial cost-savings unless proof existed of high levels of "defensive" medicine, the OTA

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<sup>2</sup> CBO PAPERS: *ESTIMATES OF HEALTH CARE PROPOSALS FROM THE 102nd CONGRESS*, July 1993.

<sup>3</sup> CBO TESTIMONY: Statement of Robert D. Reischauer Before the Committee on Ways and Means of the U.S. House of Representatives, March 4, 1992.

<sup>4</sup> Office of Technology Assessment, *Impact of Legal Reforms on Medical Malpractice Costs*, OTA-BP-H-119, October 1993.

<sup>5</sup> *Id.*

then conducted another study focused specifically on the issue of "defensive" medicine.<sup>6</sup> The OTA found that:

- There is only "weak" evidence that malpractice reform will impact defensive medicine costs.
- The effects of traditional tort reforms on defensive medicine "are likely to be small." Furthermore, in the limited instances when reforms "do reduce defensive medicine, they may do so indiscriminately, reducing appropriate as well as inappropriate practices."
- Historical experience suggests "that traditional tort reforms may not do much to reduce defensive medicine" because in "the early 1970's, when direct malpractice costs were quite low and when the malpractice signals were much weaker than they are today, there was still considerable concern about defensive medicine."
- Only "a relatively small proportion of all diagnostic procedures -- certainly less than 8 percent -- is likely to be caused primarily by conscious concern about malpractice liability risk." The OTA also stressed that this figure actually "overestimates the rate" of defensive medicine because it "is based on physicians' responses to hypothetical clinical scenarios that were designed to be malpractice sensitive".
- Most physicians who order "aggressive diagnostic procedures . . . do so primarily because they believe such procedures are medically indicated, not primarily because of concerns about liability".
- Defensive medicine "may benefit patients" by producing safer medical care.
- "Health care reform may change financial incentives toward doing fewer rather than more tests and procedures. If that happens, concerns about malpractice may act to check potential tendencies to provide too few services".

The OTA's findings regarding defensive medicine severely undermine the credibility of claims that a link exists between medical malpractice reform and defensive medicine costs. The OTA specifically contradicts the widely-cited estimate of the Lewin-VHI study<sup>7</sup> that malpractice reform might save about \$7 billion a year over the next five years in defensive medicine costs:

Recognizing the impossibility of precise measurement of defensive medicine, however defined, Lewin-VHI estimated a wide range of values. The question for the OTA is whether the reported range of defensive medicine costs is reasonably accurate. OTA concluded that, due to the questionable accuracy of the Reynolds estimate, which Lewin-VHI used as a starting point, and the weak evidence for the assumptions applied in their adjustments, the Lewin-VHI estimate is not a reliable gauge of the possible range of defensive medicine costs.<sup>8</sup>

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<sup>6</sup> Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H-602, July 1994.

<sup>7</sup> Lewin-VHI, Inc., *Estimating the Costs of Defensive Medicine*, January 27, 1993.

<sup>8</sup> Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H-602, July 1994.

The fact that the OTA's findings dispel the Lewin-VHI estimate is not surprising given that the author of the Lewin-VHI study readily admits that his conclusions are not based on verifiable empirical evidence:

Published estimates of the costs of defensive medicine are subjective and critically dependent on a variety of assumptions. Perhaps most important, it is impossible to determine the motivations of a physician who orders excessive tests, or carries out unnecessary procedures. In addition to the fear of malpractice litigation, physicians currently face a variety of other incentives to over-prescribe, including:

- Patient preferences to pursue highly aggressive treatment;
- Requirements of peer review organizations and hospitals;
- Financial incentives (e.g., fees from procedures);
- Premature application of new medical technologies;
- Lags in response to new clinical information.

Because no empirical study has been able to distinguish among these potential causes of over-use, any estimate of the overall savings that might result from elimination of defensive medical practices will depend on what is assumed about physician behavior. Other unknowns... include the likely effect of changes in the malpractice system on physician behavior; the time required to adjust to new behavioral incentives; and, left unchecked or left without change, the rate of growth in defensive medical costs over time.<sup>9</sup>

### **III. Independent Researchers Also Dispute the Cost-Savings Claims of Tort Reform Proponents**

A substantial number of independent researchers have supplemented and supported the findings of the CBO and the OTA that the federal health care budget is unlikely to be reduced by medical malpractice reform.

Princeton professor Paul Starr, a renowned expert on health care reform issues, extensively examined the potential impact of various reform proposals on U.S. health care expenditures. Starr came to the following conclusions about medical malpractice reform:

Many people, especially physicians, are convinced that high malpractice-insurance rates and the practice of defensive medicine are major sources of excessive health costs in the United States. Once again, the claim is that Americans are different -- more litigious as patients and more likely as jurors to give big verdicts for plaintiffs.

Yet the evidence does not bear out the hypothesis that malpractice litigation is a major source of the cost problem. Since malpractice insurance represents less than 1 percent of overall health costs, it cannot possibly be a primary cause of the growth in expenditures. To be sure, some medical specialties in some states have faced staggering rate increases. These periodic shocks reflect the cyclical nature of the insurance business and the inability of the insurers to spread risks beyond the members of one specialty in one state. Overall, the malpractice-insurance premiums have been virtually constant as a share of physicians costs.

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<sup>9</sup> Lewin-VHI, Inc., *Estimating the Costs of Defensive Medicine*, January 27, 1993.

The impact of defensive medicine on costs is more difficult to evaluate. Although some defensive procedures are unnecessary, others represent legitimate quality assurance. There are no good estimates of the cost of truly unnecessary procedures. We also do not know how many medical accidents and injuries defensively adopted procedures help to avoid. Thus, the *net* economic impact of defensive medicine is unclear.

Furthermore, doctors and hospitals generally make money off the procedures they perform, even if they do them defensively. Stanford health economist Victor Fuchs has asked the pointed question: 'If new legislation outlawed all future malpractice claims, by how much would physicians and hospitals voluntarily cut their present revenues?' Anyone who thinks defensive medicine is a big problem must believe that providers would sacrifice billions of dollars in lost revenues. This seems implausible.

....[Thus,] not even the most extensive changes in the malpractice system are likely to alter the general trend in health-care costs.<sup>10</sup>

Patricia Danzon, a noted scholar on medical malpractice issues and a professor at the Wharton School, agrees. She stated recently that "nobody to my knowledge has found" evidence that malpractice reforms reduce health care costs.<sup>11</sup> Danzon also stressed that even if it could be proven that malpractice reform does in fact have an impact on costs, such impact "likely would be small because malpractice costs, on average, only equal about 5 percent of physicians' gross income."<sup>12</sup>

The Harvard School of Public Health's Dr. Troyan Brennan adds that rather than leading to a reduction in health care expenditures, medical malpractice reform would actually raise costs by increasing the number of medical injuries caused by negligence. In recent testimony before the Senate Finance Committee, Brennan stated that malpractice "reforms will reduce deterrence and thus increase the number of medical injuries and the costs associated with those injuries."<sup>13</sup> He went on to explain that research conducted by the Harvard School of Public Health indicates that the additional costs resulting from such medical injuries would dwarf even the most liberal of estimates regarding the cost-savings potential of malpractice reform:

[M]edical injuries are associated with over \$60 billion in costs, all of which the medical care system and other social welfare plans now silently absorb. . . .The figure of \$60 billion is larger than the combined estimates of the costs of medical malpractice premiums (\$10 billion) and defensive medicine (\$10-\$20 billion).

The costs of medical injuries and the total morbidity and mortality associated with adverse events and negligent adverse events underline the need for greater efforts at prevention of medical injuries. This matter of great public health importance is not clearly addressed by the Health Security Act or other suggested federal reforms. The failure to address prevention is the single greatest weakness of current federal reforms of malpractice.<sup>14</sup>

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<sup>10</sup> Paul Starr, *The Logic of Health Care Reform*, 1992.

<sup>11</sup> *Effect of Tort Reform on Health Care Costs is Difficult to Pin Down, Researchers Say*, BNA's Health Law Reporter, April 6, 1995.

<sup>12</sup> *Id.*

<sup>13</sup> Testimony of Dr. Troyan Brennan on Medical Malpractice and Health Care Reform Before the Senate Finance Committee, May 12, 1994.

<sup>14</sup> *Id.*

Harvard Law School professor and noted tort reform proponent Paul Weiler's research has also indicated that extensive medical malpractice reform could increase costs by removing critical safeguards against medical negligence:

There is some evidence from our [Harvard] study that defensive medicine produces safer medical care. . . . And given that poorer quality medical care that injures patients is quite expensive not only to patients but to the health care system, having a good malpractice liability system should be a significant, but by no means major, feature of health care reform. It adds costs, but it can save costs. . . . [a]nd it can certainly save lives and limbs.<sup>15</sup>

#### **IV. Experiences in California and Other States Provide Strong Evidence that Federal Medical Malpractice Reform Will Not Reduce Health Care Costs or Premiums**

Perhaps the best indicator of whether or not federal medical malpractice reforms would reduce U.S. health care expenditures or liability insurance premiums is the experience of states that have similar reforms currently in place. The impact of reforms at the state level should provide Congress with invaluable insights as to the appropriate course of action to take at the federal level. Because California's "Medical Injury Compensation Reform Act" (MICRA) is often cited by medical and insurance groups as a model for federal malpractice reform and California's economy closely mirrors the nation at large, examining the effect of MICRA on health care costs and liability insurance premiums is a logical place to start.

The most comprehensive study on MICRA's impact to date was conducted by a California citizen organization called the Proposition 103 Enforcement Project.<sup>16</sup> This group speculated that if the "advocates of tort law restrictions are correct, health care costs in California should have dropped after MICRA's passage and should have remained below the national average [per capita] since then."<sup>17</sup> However, the evidence collected by this study paints a different picture:

*Health care costs in California have exceeded the consumer price index since the passage of MICRA -- and in recent years that growth rate has accelerated. During the period 1975 to 1993, health care costs in California, as measured by the Medical Consumer Price Index (CPI), grew 343% during that period, while CPI for all items rose 186%.*

Since 1976, the California Medical CPI increased, on the average, by 8.6% annually while the CPI for All Items increased at an average rate of 6.1% annually. During the last ten years, the annual growth rate of the state's Medical CPI has leaped ahead of the All Items CPI: between 1985 and 1993, the CPI for medical care grew at a rate nearly twice as fast as the general California CPI (averaging increases each year of 7.8% vs. 4.1%, respectively, during this period).

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<sup>15</sup> *Defensive Medicine: Cost Savings Uncertain*, ABA Journal, May 1993.

<sup>16</sup> Proposition 103 Enforcement Project, *MICRA: The Impact on Health Care Costs of California's Experiment With Restrictions on Medical Malpractice Lawsuits*, 1995.

<sup>17</sup> *Id.*

*Growth in health care costs in California has been slightly higher than national growth rates.* Between 1975 and 1993, the California Medical CPI rose 6% more than the national Medical CPI, which grew 324%. The annual growth rate of the national Medical CPI averaged 8.4% (California's was 8.6%). California's inflation rate for health care was equal to or exceeded the national rate for eleven of the eighteen years following the passage of MICRA.

*Per capital health care expenditures have been higher in California than in the nation since the passage of MICRA.* Per capital health care expenditures in California exceeded the national average every year between 1975 and 1993 by an average of 9% per year. California per capita expenditures were, on the average, \$152 higher than in the United States as a whole each year between 1975 and 1993.

*Hospital patient costs are higher in California than in other major states.* Another accurate indicator of health care expenditures is the average hospital patient cost per adjusted day which reflects outpatient as well as inpatient services. In 1993, California's average hospital patient cost per adjusted day was the highest of ten similar, densely-populated states studied. Between 1985 and 1993, California's hospital patient costs were the highest in four years (1985, 1989, 1992, and 1993) and second highest in the other two years (1988 and 1990).

These conclusions are consistent with the results of a 1992 General Accounting Office (GAO) study on health care spending at the state level.<sup>18</sup> The GAO found that per capita health care expenditures in California were second highest in the nation in both 1982 and 1990 and were considerably higher than the national average in those years (18.9% higher in 1982 and 19.3% higher in 1990) despite extensive malpractice reform.<sup>19</sup>

Data collected by the Proposition 103 Enforcement Project study "also dispute the basic claim that MICRA has lowered medical malpractice liability insurance premiums" in California.<sup>20</sup> In fact, researchers found that California's medical malpractice liability premiums actually increased by 190% in the twelve years (1976-1988) following enactment of MICRA.<sup>21</sup> To the extent that premiums have started to decline in the years since 1988, the study concluded that "recently imposed regulation of insurers" -- not MICRA -- is responsible:

In 1988, California voters approved a ballot measure, known as Proposition 103, which mandated a 20% rate rollback in all forms of property-casualty insurance, including medical malpractice, and prohibited increases in such insurance unless approved by the insurance commissioner after hearings and justification. The initiative drive, begun in 1987, was a direct response to rapid increases in liability insurance in the mid-1980's. It is likely that California's stringent regulatory process is responsible for the reduction in premiums seen in California since the beginning of the Proposition 103 process.<sup>22</sup>

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<sup>18</sup> General Accounting Office, *Health Care Spending: Nonpolicy Factors Account for Most State Differences*, GAO/HRD 92-36, February 1992.

<sup>19</sup> Id.

<sup>20</sup> Proposition 103 Enforcement Project, *MICRA: The Impact on Health Care Costs of California's Experiment With Restrictions on Medical Malpractice Lawsuits*, 1995.

<sup>21</sup> Id.

<sup>22</sup> Id.

Researchers isolated the historical "economic behavior of the insurance industry" as another non-MICRA related factor in California's reduced premiums since 1988:

Insurers rely heavily on the profits they earn from investing premium dollars. When interest rates were high in the early 70's and early 80's, insurance companies lowered premiums to compete for dollars to invest. As interest rates subsequently fell, insurers found themselves over-extended, with reduced profits. Insurers then increased their projections of future claims. . . . to justify boosting premiums to offset falling profits. In both cases, insurers blamed the legal system for the often sudden and massive rate hikes. Such dramatic increases occurred both in 1975 and 1985. State regulators intervened during the instability of the mid-1980's. Moreover, as the industry stabilizes in the post-"crisis" period, insurers often begin the cycle over again by cutting rates to increase market share -- giving the tort restrictions a facade of effectiveness. Premiums are reduced as a result.<sup>23</sup>

A third possible reason for moderating premiums in California in recent years is the increasing number of doctor-owned insurance companies:

Proponents of MICRA may argue that California's slower premium growth is due to MICRA. However, an equally credible explanation is that dramatic changes in the medical malpractice insurance marketplace after MICRA's passage are responsible. When the reduction in malpractice premiums promised by the insurance industry did not materialize after MICRA was enacted, many California medical providers established mutual insurance carriers, non-profit companies owned by doctors and hospitals to sell the needed malpractice liability coverage. These "bed pan" mutuals, as they are called, are capable of offering lower rates than the private insurers because they are not run for profit, and because they emphasize risk avoidance procedures which encourage safe medical practices. The mutuals now control a significant portion of the California medical malpractice insurance market in California, in contrast to the dominance of private for-profit insurers before 1975.<sup>24</sup>

MICRA's failure to reduce or even contain health care costs and insurance premiums in California is consistent with the experience of several other states that have enacted substantial medical malpractice reforms. According to a 1995 study by the Coalition for Consumer Rights, medical malpractice damage caps adopted in eight different states (Alaska, Colorado, Hawaii, Maryland, Massachusetts, Michigan, Missouri, and Utah) have not reduced health care spending in any of the states.<sup>25</sup> Consider the following findings from this study:

There is no evidence of consumer savings resulting from caps on damages. The eight states that imposed barriers in 1986 saw health care spending increases decline in the years before 1986, from 16.8% in 1981 to 11.4% in 1985. The decline continued after barriers were imposed, reaching 8.8% in 1989. Growth rates then increased, reaching 11.0% in 1990 and 10.8% in 1991. In the five years after imposition, growth increased from 9.2% in 10.8% in 1991; an increase of 1.6.

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<sup>23</sup> Id.

<sup>24</sup> Id.

<sup>25</sup> Coalition for Consumer Rights, *The Great Tort Liability Hoax: Caps on Jury Verdicts Produce No Savings to Consumers*, January 1995.

Likewise, states without restrictions saw health care spending increases fall from 16.0% in 1981 to 9.6% in 1985. In the second half of the decade, increases flattened out, reaching 10.5% in 1991. Spending growth increases were far more moderate in states without restrictions, growing just 0.6 between 1987 and 1991.

While the difference between the average rate of growth in states with restrictions and states without is statistically insignificant, states that did not impose restrictions on jury verdicts saw slower growth five years after imposition than states with barriers.

We found a similar trend even after adjusting health care spending for population growth: states without restrictions on victims' rights saw slower growth in health care spending than states with restrictions. Nationally, per capita health care spending grew at an average annual rate of 9.4% between 1981 and 1991. In the first half of the decade it grew 10.4% each year; in the later half, at 9.0%

Among states that put restrictions on malpractice suits, per capita health care spending growth declined from 15.3% in 1981 to 10.0% prior to imposition of barriers in 1986. Between 1987 and 1991, growth rates flattened out at around 9.0% per year, reaching 9.2% in 1991.

States without jury verdict limitations saw per capita growth fall from 14.9% in 1981 to 8.8% in 1985. The latter half saw more stable growth, settling at 9.3% in 1991.

Nowhere did we find any savings attributable to new laws restricting jury verdicts in medical malpractice cases. Any slowing of medical spending growth began long before states imposed limits on medical malpractice victims.<sup>26</sup>

This study also found that enactment of damage caps did not reduce the costs of liability insurance premiums in the eight states. Analyzing data from the nation's largest medical malpractice liability insurer (The St. Paul Company), researchers determined that malpractice liability insurance rates actually increased 15.3% in Utah, 38.6% in Missouri, and 50.8% in Colorado after the imposition of damage caps.<sup>27</sup>

Several years prior to the Project 103 Enforcement Project and Coalition for Consumer Rights studies referenced above, the GAO conducted comprehensive case studies in six states with substantial medical malpractice reforms (Arkansas, California, Florida, Indiana, New York, and North Carolina) to determine the impact of such reforms on liability insurance premiums.<sup>28</sup> The results of these GAO case studies were unanimous that medical malpractice reforms did not reduce insurance premiums in any of the six states:

From 1980 to 1986, the cost of malpractice insurance increased in each of the six states--often much more than the consumer price index and the medical care index, which increased 41 percent and 65 percent, respectively. The greatest increases were experienced by physicians in New York, Florida, and North Carolina.

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<sup>26</sup> Id.

<sup>27</sup> Id.

<sup>28</sup> General Accounting Office, *Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms*, GAO/HRD-87-21, December 1986.

## CONCLUSION

The available research conducted by various governmental and independent researchers provides strong evidence that federal medical malpractice reform would not reduce national health care expenditures, liability insurance premiums, or "defensive" medicine. In fact, it is quite possible that malpractice reform would raise health care costs by increasing the incidence of negligently inflicted medical injuries.

The growing consensus that medical malpractice liability reform will not reduce health care costs or insurance premiums has substantial public policy implications. Most importantly, it teaches us that Congress should not look to medical malpractice liability reform as a way to cut federal health care expenditures or achieve budgetary objectives.

- ♦ Medical malpractice liability reform would simply not result in any direct or indirect reduction in payments for Medicare, Medicaid or any other federally financed health care delivery program. To speculate or assume otherwise would contradict the unambiguous results of a large body of independent research.
- ♦ The likely impact of medical malpractice reform would be to increase Medicare and Medicaid by increasing the amount of negligently inflicted medical injuries. Each injury or other adverse event caused by negligent medical care typically requires: (1) additional tests and procedures; (2) extended time at a hospital; (3) the expending of additional time and resources by health care providers; and (4) additional prescriptions of medications.
- ♦ The most effective means to reduce federal health care subsidies and programs is to reduce the incidence of medical injuries resulting from malpractice through prevention and disciplinary measures unrelated to liability reform.

## THE TRUTH ABOUT COLLATERAL SOURCE "REFORM"

- ♦ It is simply a myth that a mandatory collateral source offset is necessary to prevent "double recovery" for a malpractice victim. Victims generally do not receive "double recovery" due to the doctrine of subrogation, which grants the victim's insurance company or most other collateral sources the legal right to be reimbursed by the victim from a damage award for any benefits paid.
- ♦ Even if no subrogation rights exist, the victim does not receive "double recovery" because collateral source benefits are often only a recoupment of insurance premiums or other out-of-pocket payments paid over the years by the victim to the collateral source to be eligible for future benefits.
- ♦ Requiring offsets for collateral source benefits is just plain bad public policy. Such offsets (1) allow the negligent defendant - not the victim - to profit from the victim's prudent investment in insurance or other protection; (2) undermine the deterrent effect of our malpractice system by allowing defendants to escape full liability for their negligence; (3) provide a disincentive for persons to obtain and maintain adequate insurance or other protection; and (4) can even result in the "double reduction" of a victim's award, once by the offset and again by a subrogation proceeding.
- ♦ There is a better solution to the collateral source "problem", if something must be done, that benefits both sides in a medical malpractice dispute without providing an unfair advantage to either: a two-way collateral source "evidence" rule. Unlike a collateral source "damages" rule that would blindly offset a victim's award, a two-way collateral source "evidence" rule would allow evidence of both the victim's collateral source benefits and the extent of the defendant's liability insurance coverage to be admissible. Consider the following:
  - ♦ Doctor's argue on one hand that evidence of a plaintiff's collateral benefits (resulting from the plaintiff's payment of premiums) should be admissible and that such evidence would not be prejudicial. On the other hand, however, doctor's argue that similar evidence of a doctor's liability insurance coverage (resulting from the doctor's payment of premiums) should not be admissible because it would be prejudicial. Such a position is not only wildly inconsistent, it is directly counter to fundamental notions of judicial fairness that plaintiffs and defendants should operate on a level playing field.
  - ♦ By exposing all of the evidence to the jury concerning the collateral "sources" of both the plaintiff and the defendant, a fair and equitable result is possible.
  - ♦ The bottom line is that defendants and plaintiffs should face the same evidentiary rules. To do otherwise would be to dangerously tilt the scales of justice away from victims of medical negligence.

## UNDERSTANDING "DEFENSIVE" MEDICINE

Although "defensive" medicine is often cited as a major factor in rising health care costs, no reliable empirical study has been able to measure the actual costs or distinguish among the potential causes of "defensive" medicine. Also lost in the malpractice reform debate is that, just as "defensive" driving reduces automobile accidents, careful and thorough medical care actually saves costs by preventing medical injuries.

### **I. The Costs of "Defensive Medicine" Have Never Been Accurately Measured and Would Not Be Significantly Reduced by Medical Malpractice "Reforms".**

- A landmark 1994 study by the Office of Technology Assessment exposes the many "defensive" medicine myths being perpetuated by proponents of medical malpractice reform. (OTA, 7/94). For example, the OTA concluded that the costs of "defensive" medicine are "impossible to accurately measure" and that the effects of tort reform on such costs "are likely to be small". (Id.).
- Because no hard evidence exists as to the costs or causes of "defensive" medicine, existing estimates are based on "dubious data and arbitrary assumptions." (ABA Journal, 5/93). Even the authors of the widely cited Lewin-VHI study concede that their estimate that malpractice reform might save over \$7 billion a year in "defensive" medicine costs is based on "subjective" criteria and a "variety of assumptions". (Lewin-VHI, 1/27/93). For this reason, the OTA dismissed the Lewin-VHI study as "not a reliable gauge of the possible range of defensive medicine costs." (OTA, 7/94).

### **II. Even if These Guesses at "Defensive" Medicine Cost Savings Were True, They Represent a Minuscule Portion of Health Care Costs.**

- Even if the liberal \$7 billion estimate is accurate, this demonstrates that "defensive" medicine has a relatively minor impact on overall health care costs. \$7 billion would only represent about 0.6% of the estimated \$1.03 trillion in total health care costs for 1994. (U.S. Dept. of Commerce, 1994).

### **III. Furthermore, These Estimates Do Not Present a True Argument for Malpractice Reform Since They Fail to Subtract Out Causes Other Than Fear of Liability.**

- The Lewin-VHI figure and similar "defensive" medicine cost estimates fail to distinguish "defensive" procedures conducted due to malpractice fears from those stemming from a variety of other "overlapping motivations". (Lewin-VHI, 1/27/93). Other factors causing physicians to "over-prescribe" include financial incentives (e.g., fees from procedures), patient demands and expectations, requirements of peer review organizations and hospitals, and premature application of new medical technologies. (Id.). In fact, the OTA study concluded that only "a relatively small proportion of all diagnostic procedures. . . is likely to be caused primarily by conscious concern about malpractice liability risk." (OTA, 7/94).
- As an example of how financial incentives can lead a physician to "over-prescribe", a recent GAO study found that doctors who refer patients within their own practice or to a

lab where they have an ownership interest order about 3 times as many MRI scans, 2 times as many CT scans, 4.5 to 5 times as many ultrasound scans, and 2 times as many X-rays than do physicians who refer patients outside of their practice affiliations. (GAO, 4/5/94).

- In recognition of the various incentives for "defensive" medicine, a recent CBO report concluded that even if doctors were given absolute immunity from liability, "much of the care commonly dubbed 'defensive medicine' would probably still be provided for reasons other than concerns about malpractice". (CBO, 10/92).
- Regardless of the cause, the ordering of unnecessary procedures is a problem that has been greatly exaggerated. In fact, two recent studies published in the Journal of the American Medical Association indicate that doctors are now ordering too few, not too many, procedures. (JAMA, 5/17/95). Yet another study recently published in JAMA concluded that there is "no evidence for the practice of defensive medicine" among Ob/Gyns. (JAMA, 11/22/95).

#### **IV. Also Ignored is that "Defensive" Medicine = Careful and Thorough Medical Care that Saves Costs by Preventing Medical Injuries.**

- No one denies that "defensive" medicine can prevent medical injuries by producing safer and more thorough medical care. (See, e.g., ABA Journal, quoting Harvard Law School Professor and noted tort reform advocate Paul Weiler, 5/93). Certainly extra procedures are not harmful, or else "defensive" medicine -- done for whatever reason -- would be improper and unethical. Thus, the debate about "defensive" medicine is simply whether its costs outweigh the benefits of avoiding those injuries -- essentially putting dollar figures on avoided injuries.
- Lost in this balancing of "defensive" medicine costs against prevented medical injuries has been that medical injuries themselves have substantial dollar costs. The Harvard School of Public Health's Troyan Brennan places the total costs of medical injuries at approximately \$60 billion each year -- a figure that dwarfs even the most liberal estimates of "defensive" medicine costs. (Testimony of Troyan Brennan, 11/10/93).
- By preventing some medical injuries, "defensive" medicine saves the health care system costs. (Harvard Law School Prof. Paul Weiler, quoted in ABA Journal, 5/93). In fact, some experts believe that, given the huge costs associated with medical injuries, the net effect of "defensive" medicine may be to reduce overall health care costs. (See, e.g., Testimony of Troyan Brennan, 11/10/93).

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In sum, "defensive" medicine: (1) has yet to be adequately quantified; (2) would not be significantly reduced by tort reform; (3) by universal agreement is at most a very small portion of health care costs; (4) has been overestimated in the malpractice debate because no one has properly subtracted out other causes of unnecessary procedures; and (5) must be evaluated only after considering the health care cost savings it brings by preventing medical injuries.

## MEDICAL MALPRACTICE: A DEADLY AND GROWING EPIDEMIC

Proponents of tort reform are correct that a medical malpractice "crisis" exists in the United States today, but the crisis does not relate to medical malpractice lawsuits or liability insurance premiums. The real problem with medical malpractice is medical malpractice itself. Congress should focus its "reform" efforts on reducing the staggering amount of medical malpractice that occurs each year in the United States, not reducing the rights of malpractice victims and their families to recover fair compensation

### **I. Medical Malpractice Injures or Kills Hundreds of Thousands of Americans Each Year.**

- Estimates are that each year medical malpractice causes as many as 180,000 unnecessary deaths and over a million injuries. (*Journal of the American Medical Association*, 7/5/95). Such shocking statistics place medical malpractice as the third leading cause of preventable deaths in the United States behind deaths caused by cigarettes and alcohol abuse. (*Center for Patients' Rights*).
- In fact, more people are killed by medical malpractice a year than perish due to automobile accidents (approx. 40,000), airplane crashes (approx. 1,032), and drug abuse (approx. 20,000) combined. (*Nat'l Safety Council, NTSB and Nat'l Center for Health Statistics*). We have strict seatbelt and drunk driving laws to improve highway safety, tough FAA oversight to ensure safe air travel, and comprehensive anti-drug programs to reduce substance abuse. Why is it then that Congress is now considering medical malpractice "reforms" that would decrease the incentives for the safest possible practice of medicine?
- To exacerbate matters, the rate of malpractice may actually increase in the new era of managed care as insurers and hospitals attempt to cut costs. (*Washington Post*, 8/7/95). Even Dr. James Todd of the AMA has admitted that in "the rush for cost containment, the caliber of the health-care team may be decreasing." (*Time*, 4/3/95).
- Congress must not be fooled by the intensive public relations blitz to portray doctors and insurance companies as victims in the medical malpractice debate. According to a recent study by Drs. Eugene Robin and Robert McCauley, "in comparison to the patient-victims of malpractice, the problem of doctor-victims is insignificant." (*Malpractice Crisis*, 1/94).

### **II. Despite an Epidemic of Sub-Standard Medical Care, Negligent Physicians are Rarely Disciplined and Malpractice Information is Unavailable to the Public.**

- While we punish drunk drivers, drug dealers and others who cause unnecessary deaths and injuries, medical malpractice goes largely unpunished due to lax disciplining by state medical boards and the relative ease by which negligent physicians can move from state to state. (*Wall St. Journal*, 1/13/93 & 11/11/92). This failure to discipline stems from a lack of resources, physician lawsuits at the slightest threat of disciplinary action, and a staunch unwillingness among physicians to report the mistakes of their colleagues. (Id.).
- Although hospitals and state medical boards have access to information in the National Practitioner Data Bank relating to physicians' malpractice histories, such critically important information is unavailable to the general public. (*USA Today*, 3/27/95).

## PERIODIC PAYMENT PROVISIONS MUST BE CAREFULLY CRAFTED TO SAFEGUARD THE RIGHTS OF VICTIMS

- While periodic payments of awards may seem innocuous, they can be harmful and unfair to malpractice victims unless drafted with certain protections. Periodic payments must be limited to "future" damages only because to allow "present" damages to be paid over time would be unconscionable. "Present" damages are those a victim has already incurred and which are needed to pay for outstanding bills and other necessities. Periodic payments must also be limited to future "economic" damages, such as lost wages, that accrue at intervals in the future. Disfigurement, reproductive loss, and similar types of noneconomic loss should almost never be subject to periodic payments because such loss is inflicted once at the time when the malpractice occurs.
- Like contests that promise a \$1,000,000 prize but then pay the winner \$50,000 over twenty years, allowing defendants to pay future economic damages over an extended time frame can provide a windfall to defendants by indirectly denying victims the complete compensation they were awarded. This situation can be rectified by requiring that inflation and the time value of money be considered in fashioning the amount of future installments.
- To avoid reducing a victim's award even further, it is absolutely critical that a future economic damages award not be discounted to present value before determining the payment scale. By reducing once to present value and then dividing that amount over time, the compensation is doubly reduced.
- The justification for periodic payments of future damages is to provide a measure of relief to defendants facing a large verdict. This same justification does not hold up when the damages awarded are more moderate so that immediate payment would not pose an undue burden on the defendant. Thus, any federal periodic payment provision should establish a certain minimum threshold amount (e.g., \$250,000) below which periodic payments may not be required, as done in many state periodic payment laws.
- In fairness to all parties, any periodic payment provision must have a measure of flexibility to account for contingencies that might arise and the equities of each individual case. For example, the court must retain the ability to modify the payment schedule due to changed circumstances, such as unforeseen medical problems or needs of the victim. In addition, safeguards should exist to ensure that a defendant will be both able and willing to make the required payments. Such safeguards include (1) a requirement that the defendant purchase an annuity or other security instrument to assure compliance with the payment schedule; and (2) a right for the plaintiff to petition the court for a lump sum payment of remaining damages should the defendant fail to make timely payments or become insolvent.
- Future economic damages typically represent the lost wages or other sources of lost income on which victims and their families support themselves. If the victim dies before the payments expire, such victim's family or heirs may be relying on the continuation of the payments for survival. Thus, it is important that any remaining unpaid amounts (other than those for future medical care) be discounted to present value and paid to the victim's survivors or estate after the death of the victim.

## **ABOLISHING JOINT AND SEVERAL LIABILITY HARMS VICTIMS, ESPECIALLY WOMEN, THE POOR, CHILDREN AND THE ELDERLY**

- ♦ It is simply untrue that a defendant who is not responsible for an injury can be held liable under the doctrine of joint and several liability. Joint and several liability merely means that two or more defendants whose negligent actions each alone are proven to have caused the injury or have been a necessary factor in causing an indivisible injury should bear the burden of allocating damages amongst themselves by seeking "contribution". This is a fair and reasonable system, as it is the defendants, not the victim, who are best able to say which party should pay what share of the full losses.
- ♦ If the doctrine is abolished, this would only unfairly shift this burden of allocating damages away from the negligent defendants and onto the shoulders of the innocent victim.
- ♦ In those infrequent instances when contribution is not available (due to the bankruptcy of a defendant or some other situation) and one defendant must bear additional liability, the doctrine of joint and several liability merely makes the value judgment that the remaining negligent defendant or defendants, and not the innocent victim, should bear that cost. If the other wrongdoers do not have to pay these costs, then the victim is left holding the bag.
- ♦ To exacerbate matters, abolishing joint and several liability for noneconomic damages has a disproportionately negative impact on women because they are most likely to suffer severe noneconomic loss such as loss of fertility and are less likely to have primarily economic damages. For example, if joint and several liability is eliminated for noneconomic damages, the corporate executive who misses work due to an injury caused by medical negligence would be unfettered in his ability to recover his substantial lost wages. However, a young woman who loses her ability to become a mother because of medical negligence would be made to jump through numerous hoops in recovering compensation and would face the risk of not being able to collect her damages at all. This discriminatory effect undervalues women, dismisses women's losses, and treats women's suffering as less important than the loss of money.
- ♦ Eliminating joint and several liability for noneconomic damages would also have a disproportionately negative impact on the poor, children, the elderly and other groups of individuals who tend to have greater noneconomic damages than economic damages. It is patently unfair to eliminate joint and several liability for these most vulnerable parts of our citizenry and to do so would be to send a message that these victims are less important or somehow less deserving of compensation.

## A PUNITIVE DAMAGES CAP IN MEDICAL MALPRACTICE CASES IS GROSSLY UNFAIR TO VICTIMS OF EGREGIOUS CONDUCT

- ♦ Placing a cap on punitive damages in medical malpractice cases is both unnecessary and unfair. Despite anecdotal evidence of widespread and unbridled punitive damages awards, the truth of the matter is that punitive damages are extremely rare in medical malpractice cases. In fact, only 265 medical malpractice punitive damages awards were made in the 30 years between 1963 and 1993 in the United States (Koenig and Rustad, His and Her Tort Reform: Gender Injustice in Disguise, 1994). Moreover, a recent comprehensive study of medical malpractice cases in the United States found that punitive damages were awarded in only 2% of the plaintiff verdicts in 1994 (Jury Verdict Research, 1994).
- ♦ Punitive damages are so rare in medical malpractice cases because they are not awarded in cases of simple negligence, or merely when a patient suffers a bad result. Rather, punitive damages are awarded by the court only in cases where the defendant has committed an act so atrocious and dangerous that punishment, not just compensation to the victim, is warranted. Most such awards involve egregious behavior such as sexual assault or deliberate injury, or are made in cases so shocking that the court is determined to send a deterrent message to other providers. For example, punitive damages were awarded in the following medical malpractice cases:
  1. A female patient was sedated and sexually assaulted by her physician during a physical. Dugger v. Ali, Tennessee, 1989.
  2. A woman's estranged husband, a gynecologist, deliberately referred her to an incompetent physician for a hysterectomy and then intervened in the surgery, sewing her vagina shut and ripping a hole in her bladder as punishment for a suspected extra-marital affair. Crandall-Millar v. Buena Vista Hospital, California, 1987.
  3. A male quadriplegic was sexually molested by a male orderly in a nursing home, which failed to check on the orderly's training or history. The orderly had a police record including a felony. Fisher v. Beverly Enterprises, Arkansas, 1986.
  4. A man lost bladder and bowel function after unnecessary surgery which the doctor performed as a means to resolve the doctor's financial trouble. Gonzales v. Nork, California, 1974; and
  5. A woman was fraudulently induced to undergo breast reduction surgery and then suffered serious post-surgery infections due to grossly ineffective post-operative treatment. she required serious, extensive corrective plastic surgery. The doctor also falsified medical records to cover up the wrongdoing. Baker v. Sadick, California, 1984.
- ♦ Capping punitive damages in medical malpractice cases would have a disproportionately negative impact on female patients because women are most likely to be victimized by the types of egregious conduct that lead to punitive damages. Thus, a punitive damages cap would send a dangerous message to health care providers and others that the sexual assault or molestation of woman is somehow unworthy of punishment.