



CENTER FOR JUSTICE & DEMOCRACY
185 WEST BROADWAY
NEW YORK, NY 10013
TEL: 212.431.2882
centerjd@centerjd.org
<http://centerjd.org>

BRIEFING BOOK

MEDICAL MALPRACTICE: BY THE NUMBERS

Emily Gottlieb, Deputy Director for Law and Policy
Joanne Doroshow, Executive Director

December 2015 Update

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PART 1: MEDICAL MALPRACTICE LITIGATION

❖ FEW INJURED PATIENTS FILE CLAIMS OR LAWSUITS; EXPERTS AGREE THAT WHEN CASES ARE FILED, THEY ARE NOT “FRIVOLOUS.”

Each year, hundreds of thousands of Americans are killed or injured by avoidable medical errors. [See Part 5, “Patient Safety”]. Yet, very few injured patients file claims or lawsuits.

“Medical Harm: Patient Perceptions and Follow-up Actions,” Johns Hopkins University School of Medicine Professor of Surgery Marty Makary, M.D., M.P.H. et al., 2014.

Researchers found that a lawsuit was filed on behalf of the patient in 19.9 percent of harms. In other words, “approximately 1 in 5 patient harms resulted in a lawsuit.” As the authors explained, “This is similar to the Harvard Medical Practice Study, which reported an estimated ratio of adverse event to malpractice claim of 7.6:1. Other studies have estimated that as few as 2% to 3% of patients pursue litigation. These findings all suggest that the vast majority of patient harms never result in a lawsuit.”¹

“Measuring Diagnostic Errors in Primary Care,” Johns Hopkins University School of Medicine Associate Professor of Surgery Martin Makary, M.D., M.P.H. and Johns Hopkins University School of Medicine Associate Professor of Neurology David E. Newman-Toker, M.D., Ph.D., 2013.

“Only about 1% of adverse events due to medical negligence result in a claim.”²

“2013 Civil Caseloads – Trial Courts: 2013 Statewide Medical Malpractice Caseloads and Rates,” National Center for State Courts, 2015.

NCSC data from 2013 show that med mal cases ranged from 0.06 percent to 0.20 percent of the total civil caseload in 13 of 14 states reporting.³ The highest rate was 0.35 percent in one state reporting. These rates are consistent with NCSC data from the previous year.⁴

***The Landscape of Civil Litigation in State Courts*, National Center for State Courts, 2015.**

Medical malpractice cases constitute only three percent of tort cases.⁵ This was the finding of a recent NCSC report, which examined approximately five percent of civil cases disposed in state courts nationally between July 1, 2012 and June 30, 2013.⁶ As the researchers explain, “Although medical malpractice and product liability cases often generate a great

deal of attention and criticism, they comprise only five percent of tort caseloads (less than 1% of the total civil caseload).”⁷

Medical Malpractice Payments Remained at Historic Low in 2013 Despite Slight Uptick, Public Citizen, 2014.

Public Citizen’s most recent analysis of National Practitioner Data Bank (NPDB) data found that there were 3,046 medical malpractice payments for deaths due to negligence in 2013.⁸ This means that even if one uses the low end of the IOM estimate – 44,000 deaths per year – about 14 times as many people were likely killed in hospitals in 2013 because of avoidable errors as the number of malpractice payments to survivors.⁹ Using a 2009 Hearst Newspapers estimate (*i.e.*, 200,000 deaths from medical mistakes per year), just one in 65 deaths was compensated.¹⁰ In other words, between 93 and 98 percent of deaths from medical negligence did not result in any liability payment.

Darshak Sanghavi, M.D., Chief of Pediatric Cardiology at the University of Massachusetts Medical School, 2013.

“Contrary to many doctors’ beliefs, there is no epidemic of frivolous lawsuits” and “when doctors make an actual mistake, the system is slightly biased in their favor.”¹¹

“The Empirical Effects Of Tort Reform,” Cornell University Law School Professor Theodore Eisenberg, 2012.

- “One possible factor contributing to the continued high rate of errors is that doctors do not expect to bear the full cost of harms caused by their negligence. Studies of medical error consistently find that the vast majority of patients injured by medical error do not file a claim (Weiler et al. 1993; Sloan et al. 1995; Andrews, 2006). Those that do sue often do not recover. Beyond this, hospitals do not bear the full costs of the harms caused in them even though hospitals directly and indirectly influence patients’ risk of medical error (Mello et al. (2007)).”¹²
- Experts say that those who try to argue that the system is flooded with frivolous lawsuits deceptively interchange the terms “claims” and “lawsuits” to try to make their case. In other words, “[M]isleading impressions about the medical malpractice system, such as the AMA’s statement that ‘75 percent of medical liability claims are closed without a payment to the plaintiff’ (AMA 2006) depend wholly on failing to distinguish between weak cases, which tend not receive payment, and strong cases, which every study shows to receive payment at a higher rate than that suggested by the AMA. Distinguishing between the two groups of studies is important because a claim presented to an insurer is not the same as a lawsuit. And claims against multiple defendants may lead to recovery from only one, leaving three claims without a payment but an incident with evidence of negligence.”¹³

Victor Schwartz, General Counsel, American Tort Reform Association, 2011.

“It is ‘rare or unusual’ for a plaintiff lawyer to bring a frivolous malpractice suit because they are too expensive to bring.”¹⁴

**“Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,”
Harvard School of Public Health, 2006.**

- “[P]ortraits of a malpractice system that is stricken with frivolous litigation are overblown.”¹⁵
- Lead author, David Studdert, Associate Professor of Law and Public Health at HSPH, said, “Some critics have suggested that the malpractice system is inundated with groundless lawsuits, and that whether a plaintiff recovers money is like a random ‘lottery,’ virtually unrelated to whether the claim has merit. These findings cast doubt on that view by showing that most malpractice claims involve medical error and serious injury, and that claims with merit are far more likely to be paid than claims without merit.”¹⁶ The authors found:
 - Sixty-three percent of the injuries were judged to be the result of error and most of those claims received compensation; on the other hand, most individuals whose claims did not involve errors or injuries received nothing.¹⁷
 - “The profile of non-error claims we observed does not square with the notion of opportunistic trial lawyers pursuing questionable lawsuits in circumstances in which their chances of winning are reasonable and prospective returns in the event of a win are high. Rather, our findings underscore how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information that litigation triggers.”¹⁸
 - “Previous research has established that the great majority of patients who sustain a medical injury as a result of negligence do not sue. ... [F]ailure to pay claims involving error adds to a larger phenomenon of underpayment generated by the vast number of negligent injuries that never surface as claims.”¹⁹

***The Medical Malpractice Myth*, University of Pennsylvania Law School Professor Tom Baker, 2005.**

- “[T]here are far more cases of medical malpractice than medical malpractice litigation. Professor Danzon reported that there were 10 incidents of medical malpractice for every one malpractice claim in the United States. The Harvard group found a seven-to-one ratio in New York and Colorado and a five-to-one ratio in Utah. Because hospital record reviews miss so much medical malpractice, the real multiple is much higher. ...

- “[T]he Harvard team looked at about 30,000 hospital records in New York and found conclusive evidence of a serious injury from medical malpractice in the records of 280 patients. How many of those 280 patients brought a claim? Eight. That is less than 3 percent.
- “In Utah and Colorado, the team looked at about 15,000 hospital records and found conclusive evidence of a serious injury from medical malpractice in the records of 161 patients. How many of those 161 patients brought a claim? Four. That is also less than 3 percent.”²⁰

❖ THE NUMBER (“FREQUENCY”) AND SIZE (“SEVERITY”) OF MEDICAL MALPRACTICE CLAIMS, LAWSUITS AND INFLATION-ADJUSTED PAYOUTS ARE LOW AND DROPPING.

National Practitioner Data Bank, 2014-2015.

According to the most recent National Practitioner Data Bank (NPDB) data, 8,551 medical malpractice payments were made on behalf of physicians in 2014.²¹ Moreover, NPDB data from previous years confirm that the number of medical malpractice payments made on behalf of doctors has continued to decrease.²²

Medical Malpractice Payments Remained at Historic Low in 2013 Despite Slight Uptick, Public Citizen, 2014.

- The number of medical malpractice payments made on behalf of physicians rose slightly by only 3 percent from 2012 to 2013 (*i.e.*, from 9,370 payments to 9,677 payments), remaining at a historic low.²³ Moreover, the number of medical malpractice payments in 2013 was over 40 percent lower than in 2001, the year in which the most medical malpractice payments were made.²⁴ In addition, the *per capita* number of payments in 2013 was 47 percent lower than in 2001.²⁵
- The cumulative value of malpractice payments was only 3.7 percent higher in 2013 but still “lower (in actual as well as inflation-adjusted dollars) than in any year from 1999 to 2011.”²⁶ Moreover, “[t]hese payments accounted for about 0.11 percent (*i.e.*, one-tenth of 1 percent) of national health care costs in 2013, roughly the same as in 2012.”²⁷

2013 Hospital and Physician Professional Liability Benchmark Analysis, AON Risk Solutions and American Society for Healthcare Risk Management, 2013.

- “The cost of medical malpractice [claims] is growing at the slowest rate in the fourteen year history of the Aon/ASHRM Hospital and Physician Professional Liability Benchmark report.”²⁸
- “‘We project zero growth in the number of malpractice claims,’ said Erik Johnson, health care practice leader for Aon’s Actuarial and Analytics Practice and author of the analysis. ‘Health care professional liability claims are subject to a complicated set of geographic, societal, and technological influences. These forces are largely in-check, resulting in a low inflationary environment for medical malpractice.’”²⁹

“The Receding Tide of Medical Malpractice Litigation Part 1: National Trends,” University of Illinois Professor of Law and Medicine David A. Hyman et al., 2013.

Hyman and colleagues Bernard S. Black and Myungho Paik, both from Northwestern University, found:

- “[A]ll states have experienced large drops in paid claims per physician and payout per physician.”³⁰
- “[T]he per-physician rate of paid med mal claims has been dropping for 20 years and in 2012 is less than half the 1992 level.”³¹
- “We find large drops in paid claim rates per active physician nationally and in no-cap states. ...The decline was gradual during 1992-2001, and principally involved smaller claims. From 1992-2012, paid claims per physician dropped by 57% nationally, including 51% in the 20 no-cap states, 57% in the 19 old-cap states, and 64% in the 12 new-cap states.”³²
- “This trend applies to med mal suits generally, not just to paid claims and not just to claims against physicians. We find similar trends for med mal lawsuits in the 18 states where we have data on lawsuits.”³³
- “Some of the decline in paid claims reflects a large drop (72%) in the number of small paid claims (payout < \$50k). These small claims are being squeezed out of the tort system, presumably because the expected recovery does not justify the cost of bringing them. But, we also find a sustained drop in “large” paid claims (> \$50k) beginning no later than 2001. These claims account for 98% of payout dollars. Over 1992-2012, large paid claims dropped nationally by 49%, including 40% in no-cap states, 49% in old-cap states, and 60% in new-cap states.”³⁴
- “Payouts per physician have been dropping since 2003, and by 2012 were 48% below their 1992 level.”³⁵
- “Between 1992 and 2001, payout per physician rose somewhat from \$7,500 to \$8,200. Since then, it has plummeted to \$3,850 in 2012.”³⁶

**“The Receding Tide of Medical Malpractice Litigation Part 2: Effect of Damage Caps,”
University of Illinois Professor of Law and Medicine David A. Hyman et al., 2013.**

After analyzing 20 years’ worth of NPDB data, Hyman and colleagues Bernard S. Black and Myungho Paik, both from Northwestern University, found “strong evidence that damage caps reduce both claim rates and payout per claim, with a large combined impact on payout per physician. The drop in claim rates is concentrated in claims with larger payouts – the ones that would be most affected by a damages cap. Stricter caps have larger effects.”³⁷

“Five Myths of Medical Malpractice,” University of Illinois Professor of Law and Medicine David A. Hyman and University of Texas Law Professor Charles Silver, 2013.

- Because the overwhelming majority of payments to plaintiffs are the result of voluntary settlements, one must study closed claims (rather than jury verdicts) to get a full picture of what is going on. Using both federal and state closed claims databases, studies have found that both the frequency of malpractice claiming and the payments per claim were either stable or declining during the period that preceded the latest malpractice crisis, which began in 1999 to 2000.³⁸
- The finding that the latest malpractice crisis was not caused by spikes in malpractice claims or payouts should not be surprising. Although hot spots can occur, the liability system primarily responds to (and lags) the frequency of serious medical injuries. Because the frequency of serious medical injuries changes slowly, the litigation rate should not be prone to dramatic spikes in claiming.”³⁹

Empirical Studies, National Center For State Courts/U.S. Department Of Justice, 2007, 2011.

- In an October 2011 study, NCSC researchers found that from 2000 to 2009, med mal filings fell by 18 percent in the general jurisdiction courts of seven states reporting.⁴⁰ In five of those states, filings fell by between 18 and 42 percent.⁴¹ These findings are consistent with NCSC’s April 2011 med mal report which concluded that “[c]ontrary to the claims of some tort reform advocates, medical malpractice caseloads have been decreasing over time.”⁴²
- According to DOJ’s most recent report on medical malpractice insurance claims in seven states from 2000 through 2004, most claims were closed without any compensation provided to those claiming a medical injury.⁴³

True Risk: Medical Liability, Malpractice Insurance And Health Care, Americans for Insurance Reform, 2009.

Medical malpractice claims, inflation-adjusted, are dropping like a rock, down 45 percent since 2000, according to the insurance industry’s own data. Inflation-adjusted per doctor claims dropped since 2002 from \$8,676.21 that year to \$5,217.49 in 2007 to \$4,896.05 in 2008.⁴⁴ In fact, at no time during the last decade did claims spike or “explode.” As A.M. Best put it, “Overall, the most significant trend in [medical professional liability insurance] results over the five years through 2008 is the ongoing downward slope in the frequency of claims....”⁴⁵

❖ A SMALL NUMBER OF DOCTORS ARE RESPONSIBLE FOR MOST MALPRACTICE PAYOUTS; EVEN THE MOST INCOMPETENT PHYSICIANS ARE RARELY HELD ACCOUNTABLE BY STATE MEDICAL BOARDS OR THE FEDERAL GOVERNMENT.

Surgeon Scorecard, ProPublica, 2015

A “small share of doctors, 11 percent, accounted for about 25 percent of the complications. Hundreds of surgeons across the country had rates double and triple the national average. Every day, surgeons with the highest complication rates in our analysis are performing operations in hospitals nationwide.”⁴⁶ Moreover, “[m]any hospitals don’t track the complication rates of individual surgeons and use that data to force improvements. And neither does the government.”⁴⁷

Medicare Program: Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers, U.S. Government Accountability Office, 2015

According to the GAO report, the Centers for Medicare & Medicaid Services (CMS) made an estimated \$59.9 billion in improper over payments to medical providers in the fiscal year 2014.⁴⁸ As reported by the *Wall Street Journal*, this figure “includes payments to ineligible providers, for services that aren’t covered and duplicate payments, among other things.”⁴⁹

GAO also found 147 doctors “listed as eligible to bill Medicare who, as of March 2013, had received a final adverse action from a state medical board for crimes against persons, financial crimes, and other types of felonies but were either not revoked from the Medicare program until months after the adverse action or never removed.” This was despite the fact that “physicians applying to participate in the Medicare program must hold an active license in the state they plan to practice and self-report final adverse actions, such as a suspension or revocation by any state licensing authority.”⁵⁰

National Practitioner Data Bank, 2014-2015.

According to the most recent data from the National Practitioner Data Bank (NPDB), which collects “adverse action information, including state licensure and certification actions, clinical privileges/panel membership and professional society membership actions” taken against physicians,

- In 2014, only 5,288 adverse actions were taken that reduced, restricted, suspended, revoked or denied physicians’ clinical privileges or membership in a health care entity.⁵¹
- The 2014 data are consistent with previous years, where the adverse action numbers have been equally low: 5,731 (in 2013), 5,340 (in 2012) and 5,340 (in 2011).⁵²

“Why Medicare Keeps Paying Sketchy Doctors,” *Bloomberg Businessweek*, May 1, 2014.

At least eight doctors whose medical licenses were suspended or revoked collectively billed Medicare more than \$7 million in 2012. According to federal records, “Medicare approved payments to physicians who’d been disciplined for gross malpractice, battery, and violating prescription drug laws. Some had lost their licenses in their home states but were able to keep practicing by obtaining a license in another.”⁵³

Questionable Doctors, New York Public Interest Research Group et al., 2014.

After analyzing the work of the New York State Department of Health’s Office of Professional Medical Conduct (OPMC) over the past ten years, NYPIRG found⁵⁴:

- Over 77% of doctors sanctioned for negligence by OPMC were allowed to continue to practice. One of the arguments as to why New York State does not revoke questionable doctors’ licenses is that they are an important resource. However, over the past ten years, New York’s population has grown by about 2%. Its doctor population has swelled by 36%.

“Doctors, medical staff on drugs put patients at risk,” *USA Today*, April 17, 2014.

- “The latest drug use data from the U.S. Substance Abuse and Mental Health Services Administration, released in 2007, indicated that an average of 103,000 doctors, nurses, medical technicians and health care aides a year were abusing or dependent on illicit drugs. Various studies suggest the number could be far higher; an estimated one in 10 practitioners will fall into drug or alcohol abuse at some point in their lives, mirroring the general population.”⁵⁵
- “Safeguards to detect and prevent drug abuse in other high-risk industries rarely are employed in health care. No state has universal drug testing requirements, and hospitals, nursing homes and other facilities almost never do so on their own. Many institutions also lack video surveillance and high-tech systems to track dangerous drugs.”
- “Many states lack rules to ensure that medical facilities alert law enforcement or regulatory agencies if they catch employees abusing or diverting drugs, so those staffers often are turned loose to find new jobs without treatment or supervision. Disciplinary action for drug abuse by health care providers, such as suspension of a license to practice, is rare and often doesn’t occur until a practitioner has committed multiple transgressions.”

“Medicare Drug Program Fails to Monitor Prescribers, Putting Seniors and Disabled at Risk,” ProPublica, 2013.

“ProPublica’s examination of Part D data from 2007 through 2010 showed that, in many cases, Medicare failed to act against providers who have been suspended or disciplined by other regulatory authorities. Doctors barred by state Medicaid programs for questionable prescribing remain able to dole out the same drugs under Medicare. So can dozens of practitioners who have been criminally charged or convicted for problem prescribing, or who have been disciplined by state medical boards.”⁵⁶

Moreover, Medicare, “in its drive to get drugs into patients’ hands, has failed to properly monitor safety. An analysis of four years of Medicare prescription records shows that some doctors and other health professionals across the country prescribe large quantities of drugs that are potentially harmful, disorienting or addictive. Federal officials have done little to detect or deter these hazardous prescribing patterns.”⁵⁷

Public Citizen’s Report On Dangerous Texas Medical Board Enforcement Deficiencies: Their Causes and Solutions, Public Citizen Health Group Senior Adviser Sidney M. Wolfe, M.D. et al., 2012.

As stated in Public Citizen’s August 22, 2012 press release,⁵⁸

- An analysis of NPDB data found that “[f]ifty-eight percent of Texas doctors who have been sanctioned for serious offenses by health care entities, mainly hospitals, over the past two decades have never been disciplined by the state medical board.” That amounts to 459 physicians yet to be disciplined.
- “As of August 31, 2011, 454 cases had been open for at least a year, including cases going back as far as 2007, 2006 and 2005. This indicates that the board has not been following its own standards for more prompt review, which is especially dangerous in light of the grievous nature of many of the violations.”
- “Many of the [459] physicians were disciplined by hospitals and other health care institutions because they were deemed an immediate threat to the health and safety of patients, incompetent or negligent, they committed sexual misconduct or insurance fraud, they abused drugs or alcohol, or they provided substandard care to patients.”
- A quarter of the 459 physicians have been sanctioned by health care facilities more than once.
- “Nearly half of the 459 physicians had one or more medical malpractice reports. One of these physicians had clinical privileges restricted by a peer review committee in 2010 for substandard care. The physician had 11 medical malpractice payments between 1993 and

2011 for a total payout of \$2.1 million, the reasons for which included: failure to diagnose (four cases); improper performance (two cases); improper management (two cases); failure to treat; improper technique; and performing an unnecessary procedure. One of the cases involved the death of a patient.”

Public Citizen’s Health Research Group Ranking of the Rate of State Medical Boards’ Serious Disciplinary Actions, 2009-2011, Public Citizen Senior Health Adviser Sidney M. Wolfe, M.D. et al., 2012.

According to a May 2012 Public Citizen analysis of Federation of State Medical Boards data⁵⁹:

- There is a “remarkable variability in the rates of serious disciplinary actions taken by the state boards.”
- “Once again, only one of the nation’s 15 most populous states, Ohio, is represented among those 10 states with the highest disciplinary rates. For the fourth year in a row, one of the largest states in the country, Florida, although showing some improvement, is still among the 10 states with the lowest rates of serious disciplinary actions.”
- “[T]here is considerable evidence that most boards are underdisciplining physicians.”
- “Most states are not living up to their obligations to protect patients from doctors who are practicing medicine in a substandard manner. ...Action must then be taken, legislatively and through pressure on the medical boards themselves, to increase the amount of discipline and, thus, the amount of patient protection. Without adequate legislative oversight, many medical boards will continue to perform poorly.”

The Great Medical Malpractice Hoax: NPDB Data Continue to Show Medical Liability System Produces Rational Outcomes, Public Citizen, 2007.

- According to Public Citizen’s 2007 analysis of National Practitioner Data Bank (NPDB) files:
 - “The vast majority of doctors – 82 percent – have never had a medical malpractice payment since the NPDB was created in 1990.”⁶⁰
 - “Just 5.9 percent of doctors have been responsible for 57.8 percent of all malpractice payments since 1991, according to data from September 1990 through 2005. Each of these doctors made at least two payments.”⁶¹
 - “Just 2.3 percent of doctors, having three or more malpractice payments, were responsible for 32.8 percent of all payments.”⁶²

- “Only 1.1 percent of doctors, having four or more malpractice payments, were responsible for 20.2 percent of all payments.”⁶³
- However,
 - “Only 8.61 percent of doctors who made two or more malpractice payments were disciplined by their state board.”⁶⁴
 - “Only 11.71 percent of doctors who made three or more malpractice payments were disciplined by their state board.”⁶⁵
 - “Only 14.75 percent of doctors who made four or more malpractice payments were disciplined by their state board.”⁶⁶
 - **“Only 33.26 percent of doctors who made 10 or more malpractice payments were disciplined by their state board** – meaning two-thirds of doctors in this group of egregious repeat offenders were not disciplined at all.”⁶⁷

❖ "TORT REFORMS" KEEP LEGITIMATE CASES FROM BEING FILED.

"Uncovering the Silent Victims of the American Medical Liability System,"
Emory University Associate Law Professor Joanna Shepherd, 2014.

After conducting a national survey of attorneys to determine medical malpractice victims' access to the civil justice system, Shepherd found "evidence confirming that many legitimate victims of medical malpractice have no meaningful access to the civil justice system."⁶⁸ Among Shepherd's conclusions from the survey results and additional analysis of empirical studies:

- "As a result of the high costs of medical malpractice investigation and litigation, many malpractice victims are left without legal remedy. ... Unfortunately, most legislative reforms over the past several decades have only exacerbated the access-to-justice problem. Damage caps and other tort reforms that artificially reduce plaintiffs' damage awards also reduce contingent fee attorneys' expected recoveries. As a result, even fewer cases make economic sense for the attorneys to accept."⁶⁹
- Private-industry claims data show that "95% of medical malpractice victims have extreme difficulty finding legal representation unless their damages are significantly larger than the typical damages for their types of injuries."⁷⁰
- "Data also suggest that the problem of access to justice is worsening; half as many victims with low damage awards recovered in 2010 as they did twenty-five years earlier. The economic realities of the medical liability system are silencing a growing number of victims."⁷¹
- "Victims who cannot attain legal representation are effectively excluded from the civil justice system. Because of the complexity and expense of medical malpractice lawsuits, employing a lawyer is critical to a successful claim. Thus, without legal representation, most of these victims will not be compensated for the harm they suffer as a result of medical negligence. In turn, the medical liability system will fail to provide adequate precautionary incentives for healthcare providers."⁷²
- "Empirical evidence suggests that the lack of victim compensation has, in turn, reduced the liability system's deterrent effect by blunting incentives for the medical community to improve care; most studies find that malpractice liability does not influence physician behavior."⁷³

❖ PHYSICIANS GREATLY MISPERCEIVE THE RISK AND CONSEQUENCES OF BEING SUED; PERSONAL ASSETS NOT AT RISK.

“Five Myths of Medical Malpractice,” University of Illinois Professor of Law and Medicine David A. Hyman and University of Texas Law Professor Charles Silver, 2013.

- Many physicians seem to believe that malpractice verdicts threaten to wipe out their savings. When assessing this fear, it is appropriate to start by observing that jury trials are uncommon and that plaintiff victories are even less common. ...[M]ost malpractice cases are settled or dismissed; only about 2% of claims are tried, and at trial, providers win about 75% of the time.⁷⁴
- “We also learned something that may surprise many readers. When payments above the policy limits were made, whether in tried or in settled cases, they almost always came from insurers. Out-of-pocket payments by physicians were extraordinarily rare, particularly when physicians had policy limits of \geq \$500,000. One might say, with only the slightest exaggeration, that physicians have effectively no personal exposure on malpractice claims (other than the obvious and unavoidable side effects of litigation, eg, the emotional and time-related costs of being deposed). Why do plaintiffs’ lawyers not pursue personal assets? Years ago, a qualitative study documented a strong social norm among malpractice lawyers against seeking “blood money” from individual physicians. Our findings buttress that account. The only physicians who should worry about personal exposure are those who grossly underinsure, and even they should not worry too much.”⁷⁵

“The Empirical Effects Of Tort Reform,” Cornell University Law School Professor Theodore Eisenberg, 2012.

“A bizarre aspect of the medical malpractice reform debate is the recognition that doctors grossly misperceive the system, accompanied by recommendations to change the system to cater to their misimpressions. Rather than educate doctors about reality, one reads of proposals to change the system to cater to physicians’ misperceptions (Hermer and Brody 2010). It seems preferable to include a reasonable medical education requirement focusing on how the legal system operates in medical malpractice cases rather than to curtail the current liability system that is widely recognized as underenforcing standard-of-care norms.”⁷⁶

“Physicians’ Fears Of Malpractice Lawsuits Are Not Assuaged By Tort Reforms,” *Health Affairs*, 2010.

Doctors’ fear of lawsuits is “out of proportion to the actual risk of being sued” and enacting “tort reforms” have no impact on this phenomenon, according to an article in the September 2010 edition of *Health Affairs* by David Katz, M.D., Associate Professor of Medicine with University of Iowa Health Care (and several other authors).⁷⁷ Several

explanations are suggested for this undue fear. One squarely blames the medical societies, which continuously hype the risk of lawsuits to generate a lobbying force to help them advocate for doctors' liability limits. A second possible explanation is that doctors will "exaggerate their concern about being sued, using it as a justification for high-spending behavior that is rewarded by fee-for-service payment systems." A third explanation relates to well-documented human tendencies to overestimate the risk of unfamiliar and uncommon events, such as a fear of plane crashes compared to much more common car crashes. They write, "Lawsuits are rare events in a physician's career, but physicians tend to overestimate the likelihood of experiencing them."

❖ COMPENSATION IS FOR SERIOUS INJURIES OR DEATH; HIGH VERDICTS ARE ALMOST ALWAYS SLASHED; AND PUNITIVE DAMAGES ARE EXTREMELY RARE.

Medical Malpractice Payments Remained at Historic Low in 2013 Despite Slight Uptick, Public Citizen, 2014.

Public Citizen’s most recent analysis of National Practitioner Data Bank (NPDB) data shows that the overwhelming majority of medical malpractice payments compensate for death, catastrophic harms or serious permanent injuries.⁷⁸ More specifically,

- “Of the 9,677 medical malpractice payments on behalf of doctors in 2013, more than three-fifths (62 percent) compensated for negligence that resulted in a significant permanent injury, major permanent injury, quadriplegia, brain damage, the need for lifelong care, or death.”⁷⁹
- The dollar value of payments for these extremely serious outcomes accounted for over four-fifths (81.4 percent) of the total value of malpractice payments last year. “Insignificant injury” and “emotional injury only,” respectively, accounted for between 0.2 percent and 0.7 percent of dollars paid in 2013.⁸⁰
- Nearly half the money paid (44.1 percent) compensated victims and victims’ survivors for negligence resulting in death, quadriplegia, brain damage or injuries requiring lifelong care.⁸¹

“Five Myths of Medical Malpractice,” University of Illinois Professor of Law and Medicine David A. Hyman and University of Texas Law Professor Charles Silver, 2013.

- “[T]he outlandish jury verdicts that attract popular attention are not at all representative and often are slashed dramatically by judicial oversight or through other means. More broadly, the overwhelming majority (> 95%) of cases are resolved, and the overwhelming majority of payouts are made as a result of voluntary settlement.”⁸²
- “If one focuses on outputs, the liability system does much better than conventional wisdom suggests; it sorts the wheat from the chaff reasonably well. Focusing on those who initiate claims, patients treated negligently recover damages far more often than patients who were treated nonnegligently. There is also a well-established severity gradient: Payments increase with injury severity, with the exception of a death discount (ie, those who die receive less than those who are severely and permanently injured). Unfortunately, most patients are undercompensated, and those with the most severe injuries suffer the biggest gap between provable injuries and the amounts they recover.”⁸³

- “Using data from the Illinois Department of Insurance closed claims database from 2005 to 2008, we find that the mean payout was \$626,827 (median, \$454,060), but the amount paid was more modest for less-severe injuries. To receive more than the mean and median payout, one had to suffer at least significant permanent injury. Further, the ceiling on payouts is modest: Those who suffered grave and permanent injuries received a mean payout of only \$1.25 million and a median payout of about \$1 million.”⁸⁴
- “[O]bjective figures drawn from a closed claims database maintained by the Texas Department of Insurance [show] that even in a state as large as Texas (population of almost 25 million), there were only 7,650 malpractice claims per year during the pre-reform period, and tort reform caused the number of claims to decline substantially to 5,300 per year. Both pre-reform and post-reform, most (80%–85%) of these claims closed without payment. When there was a payment, it was almost always the result of a voluntary settlement; that is, trials were rare. Across all paid cases, the mean payout was \$609,000 during the prereform period and \$419,000 during the postreform period. Jury verdicts were substantially higher, but there was a significant ‘haircut’ before they were paid.”⁸⁵
- “When one compares actual payments to jury awards, many patients who win turn out to be losers as well. Because jurors tend to be stingy, awards often fail to cover patients’ actual losses. Blockbuster verdicts dominate the press, but their coverage reflects their rarity. Reporters are interested in big verdicts for the same reason they are interested in airplane crashes: Both are unusual. Any verdict, blockbuster or otherwise, that exceeds the limits of a provider’s insurance coverage is quite unlikely to be paid in full. Our study of Texas jury verdicts, which was based on an enormous closed claim database maintained by the Texas Department of Insurance, quantified the frequency and magnitude of verdict haircuts, where the plaintiff received less than the jury awarded. We found that the larger the verdict, the more likely and larger the haircut because policy limits serve as a functional cap on patients’ recoveries. Stated differently, the portion of a jury award that exceeds the available insurance coverage is rarely collectible. Other studies have documented similar haircuts with large verdicts.”⁸⁶

Empirical Studies, National Center For State Courts/U.S. Department Of Justice, 2009, 2011.

- According to NCSC, in 2005, death was by far the most frequent type of injury among successful medical malpractice plaintiffs, accounting for 22 percent of med mal victims who prevailed at trial.⁸⁷ “[I]n the paralysis/amputation category, 100 percent of medical malpractice cases in which the plaintiff received an award involved paralysis caused by injury to the spine or brain...In the brain/head injury category, all injuries alleged by successful medical malpractice claimants were permanent...For burns, lacerations, skin infections, and other skin injuries, all winning medical malpractice patients suffered permanent injuries....”⁸⁸
- In 2005, the latest year studied by DOJ, the median award for successful medical malpractice plaintiffs in state court was \$400,000.⁸⁹ The median med mal award in jury-

decided cases was also \$400,000.⁹⁰ In contrast, state judges handed down a significantly higher median damage award to medical malpractice victims, \$631,000.⁹¹ It is important to note that these median amounts do not account for post-trial activity (such as award modifications) and appeals.⁹² NCSC explained that “[t]he larger damage awards in medical malpractice cases do not necessarily imply that juries are acting irrationally or being overly generous to medical malpractice plaintiffs. First, damage awards in medical malpractice cases are generally proportionate to the severity of the injury. Second, the high cost of pursuing a medical malpractice claim means that only those cases in which the plaintiff’s injury is severe and the potential damages very large are likely to make it to trial. Because other types of tort cases are less costly to litigate, lower-value cases of these types are more likely to be filed and taken to trial than are low-value medical malpractice cases.”⁹³

- In 2005, the most recent year studied by DOJ, punitive damages were awarded in only 1 percent of medical malpractice cases where victims established liability at trial.⁹⁴ Long-term data from the nation’s 75 most populous counties show that the percentage of successful medical malpractice plaintiffs receiving punitive damages is consistently low — 1.1 percent in 1996, 4.9 percent in 2001 and 2.6 percent in 2005.⁹⁵
- After examining the most recent DOJ data available, NCSC researchers found that “[t]he most serious injuries, such as paralysis and cancer, received the largest awards. Consistent with other research, in medical malpractice cases death tended to be compensated somewhat less highly than some other serious injuries such as paralysis, in part because these injuries often require costly lifelong care. Less serious injuries, such as fractures and dental injuries, received smaller awards.”⁹⁶

“The Empirical Effects Of Tort Reform,” Cornell University Law School Professor Theodore Eisenberg, 2012.

“The effect of caps and other reforms may help explain increasing awards in medical malpractice cases that reach trial. The number of lawsuits decreases, as suggested by NCSC filing data, but caps require attorneys to be more selective about the cases they accept. ... This greater selectivity and need for greater damages to accept a case likely contribute to the increasing observed mean and median medical malpractice awards in cases that do reach trial. Garber et al. (2009) used a survey of 965 plaintiffs’ attorneys to assess whether noneconomic damages caps and attorney fee limits affected access to justice for medical malpractice victims. They concluded that caps and fee limits make it harder to retain counsel.”⁹⁷

***American Juries: The Verdict* and “The Verdict on Juries,” Cornell University Law Professor Valerie P. Hans and Duke University Law Professor Neil Vidmar, 2007, 2008, respectively.**

- “The fact that the jury verdict is not the end of litigation is often overlooked in discussions of the role of the jury. This is especially true of medical malpractice trials.”⁹⁸

According to the authors, “Research consistently indicates that outlier verdicts seldom withstand postverdict proceedings. The judge may reduce the award by *remittitur* (the legal term for a reduction), or the case may be appealed to a higher court at which time the award may be reduced. Perhaps most common of all, the plaintiff and the defendant negotiate a posttrial settlement that is less than the jury verdict. Plaintiffs are willing to negotiate lesser amounts,” the researchers added, “because they need the money immediately and cannot wait for the years it will take to get the money if the case is appealed. Also, there is a risk that an appeals court will reduce the award or even overturn the verdict.”⁹⁹ In the end, the plaintiff “negotiates a settlement around the defendant’s insurance coverage.”¹⁰⁰

- For example, “[s]ome of the largest medical malpractice awards in New York that made national headlines ultimately resulted in settlements between 5 and 10 percent of the original jury verdict actually being paid.”¹⁰¹ Similarly, “Vidmar’s Illinois study found that settlements in his sample of large jury awards averaged only 43 percent of the original verdicts.”¹⁰²
- Hans and Vidmar “explored the claims of doctors ...about unfair treatment by juries but the empirical evidence does not back them up. The notion of the pro-plaintiff jury is contradicted by many studies that show both actual and mock jurors subject plaintiffs’ evidence to strict scrutiny.”¹⁰³
- Interviews with North Carolina jurors who decided medical malpractice cases led Professor Vidmar to conclude that “many jurors initially viewed the plaintiffs’ claims with great skepticism. Their attitudes were expressed in two main themes. First, they said that too many people want to get something for nothing, a skeptical attitude about claiming... . Second, they expressed the belief that most doctors try to do a good job and should not be blamed for a simple human misjudgment.”¹⁰⁴ Vidmar added, “Indeed, these attitudes were even expressed in some of the cases in which jurors decided for the plaintiff. One jury that gave a multimillion-dollar award for a baby with severe brain injuries was very concerned about the possible adverse effect on the doctor’s medical practice. This does not mean that in every such case jurors held these views. Sometimes, evidence of the doctor’s seemingly careless behavior caused jurors to be angry about what happened. However, even in these latter cases, the interviews indicated that the jurors had initially approached the case with open minds.”¹⁰⁵

“Do Defendants Pay What Juries Award? Post-Verdict Haircuts in Texas Medical Malpractice Cases, 1988–2003,” University of Illinois Professor of Law and Medicine David A. Hyman et al., 2007.

Research by Hyman and colleagues from the University of Texas, New York University Law School and Georgetown University Law Center shows that most med mal jury awards receive post-verdict “haircuts.”¹⁰⁶

According to the Texas data:

- “Seventy-five percent of plaintiffs received a payout less than the adjusted verdict (jury verdict plus pre-judgment and post-judgment interest), 20 percent received the adjusted verdict (within \pm 2 percent), and 5 percent received more than the adjusted verdict.”¹⁰⁷
- “Overall, plaintiffs received a mean (median) per-case haircut of 29 percent (19 percent), and an aggregate haircut of 56 percent, relative to the adjusted verdict.”¹⁰⁸
- “The larger the verdict, the more likely and larger the haircut. For cases with a positive adjusted verdict under \$100,000, 47 percent of plaintiffs received a haircut, with a mean (median) per-case haircut of 8 percent (2 percent). For cases with an adjusted verdict larger than \$2.5 million, 98 percent of plaintiffs received a haircut with a mean (median) per-case haircut of 56 percent (61 percent).”¹⁰⁹
- “Insurance policy limits are the most important factor explaining haircuts.”¹¹⁰
- “Most cases settle, presumably in the shadow of the outcome if the case were to be tried. That outcome is not the jury award, but the actual post-verdict payout. ... The parties surely bargain in the shadow of the jury, but in most cases, the terms of the bargain are shaped by the shadow of coverage.”¹¹¹
- “Because defendants rarely pay what juries award, jury verdicts alone do not provide a sufficient basis for claims about the performance of the tort system.”¹¹²

“Doctors & Juries,” University of Missouri-Columbia Law Professor Philip G. Peters, Jr., 2007.

Professor Peters analyzed three decades of empirical research on jury decision-making and reached the following four conclusions: “First, negligence matters. Weak cases rarely win, close cases do better, and cases with strong evidence of medical negligence fare best. Second, the agreement rate between juries and experts is very high in the class of cases that most worries critics of malpractice litigation, that is, cases with weak evidence of negligence. Juries agree with expert reviewers in eighty to ninety percent of these cases. That is a better agreement rate than physicians typically have with each other. Third, the agreement rate is much lower in cases with strong evidence of negligence. Doctors consistently win about fifty percent of the cases that experts believe the plaintiffs should win. Fourth, the consistently low success rate of malpractice plaintiffs in cases that expert reviewers feel they should win strongly suggests the presence of one or more factors that systematically favor medical defendants in the courtroom, such as better litigation teams or pronounced jury reluctance to find doctors liable. From the perspective of defendants at least, jury performance is remarkably good.”¹¹³

Congressional Testimony, Duke University Law Professor Neil Vidmar, 2006.

Professor Vidmar told Congress in June 2006, “[T]he magnitude of jury awards in medical malpractice tort cases positively correlated with the severity of the plaintiffs’ injuries, except that injuries resulting in death tended to result in awards substantially lower than injuries resulting in severe permanent injury, such as quadriplegia. I and two colleagues conducted a study of malpractice verdicts in New York, Florida, and California. We also found that jury awards of prevailing plaintiffs in malpractice cases were correlated with the severity of the injury.”¹¹⁴

❖ MEDICAL MALPRACTICE CASES ARE NOT CLOGGING THE COURTS; JURIES RESOLVE FEW CASES AND STRONG CASES SETTLE.

“2013 Civil Caseloads – Trial Courts: 2013 Medical Malpractice Jury Trials and Rates,” National Center for State Courts, 2015.

In 2013, the percentage of med mal cases resolved through jury trial was low in all 13 states reporting, ranging from 3 percent to 9 percent of cases.¹¹⁵ More specifically, of those 13 states:

- The med mal jury trial rate totaled less than 3 percent in three states reporting.
- The med mal jury trial rate totaled between 3 and 6 percent in five states reporting.
- The med mal jury trial rate totaled between 6 and 9 percent in three states reporting.
- Only two states reported med mal jury trial rates above 9 percent.
- These rates are consistent with NCSC data from the previous year.¹¹⁶

Empirical Studies, U.S. Department of Justice, 2009.

In 2005, the most recent year studied by the U.S. Department of Justice (DOJ), only 7.8 percent of medical malpractice cases were disposed of by bench or jury trial in 49 jurisdictions reporting.¹¹⁷ Between 1996 and 2005, the number of medical malpractice trials concluded in state courts in the nation’s 75 most populous counties remained low and fairly stable, increasing by only 1.5 percent over the ten-year period.¹¹⁸ In 2005, medical malpractice cases accounted for only 9.1 percent of all *civil* cases disposed of by trial in state courts.¹¹⁹ After examining long-term data, DOJ found that the number of med mal cases as a percentage of all *civil* trials in the nation’s 75 most populous counties remained low and relatively steady over a 14-year period, with med mal cases constituting 9.7 percent of all *civil* trials in 2001 and 11.3 percent of all *civil* trials in 2005.¹²⁰ DOJ data show that in 2005 medical malpractice cases accounted for 14.9 percent of *tort* cases disposed of by trial in state courts nationwide.¹²¹ Long-term data from the nation’s 75 most populous counties show that the number of medical malpractice cases as a percentage of all *tort* trials remained low and fairly stable from 1996 through 2005, increasing by only 2.8 percent between 2001 and 2005.¹²²

“Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,” Harvard School of Public Health, 2006.

The closed claims study found that only 15 percent of claims were decided by trial verdict.¹²³ Other research shows that 90 percent of cases are settled without jury trial, with some estimates indicating that the figure is as high as 97 percent.¹²⁴

Congressional Testimony, Duke University Law Professor Neil Vidmar, 2006.

Vidmar testified before the U.S. Senate, “Research on why insurers actually settle cases indicates that the driving force in most instances is whether the insurance company and their lawyers conclude, on the basis of their own internal review, that the medical provider was negligent....An earlier study by Rosenblatt and Hurst examined 54 obstetric malpractice claims for negligence. For cases in which settlement payments were made there was general consensus among insurance company staff, medical experts and defense attorneys that some lapse in the standard of care had occurred. No payments were made in the cases in which these various reviewers decided there was no lapse in the standard of care.”¹²⁵

Vidmar added, “In interviews with liability insurers that I undertook in North Carolina and other states, the most consistent theme from them was: ‘We do not settle frivolous cases!’ The insurers indicated that there are minor exceptions, but their policy on frivolous cases was based on the belief that if they ever begin to settle cases just to make them go away, their credibility will be destroyed and this will encourage more litigation.”¹²⁶

Vidmar further testified, “Without question the threat of a jury trial is what forces parties to settle cases. The presence of the jury as an ultimate arbiter provides the incentive to settle but the effects are more subtle than just negotiating around a figure. The threat causes defense lawyers and the liability insurers to focus on the acts that led to the claims of negligence.”¹²⁷

❖ **LAWSUITS FILED FOR MEDICAL NEGLIGENCE ARE NOT FRIVOLOUS, YET IT IS STILL DIFFICULT FOR PATIENTS TO PREVAIL.**

Empirical Studies, National Center for State Courts/U.S. Department of Justice, 2009, 2011.

- DOJ found that the plaintiff win rate for medical malpractice was only 23 percent in 2005.¹²⁸ Juries decided against medical malpractice plaintiffs more than three-quarters of the time.¹²⁹ Injured patients were more successful before judges, winning 50 percent of the time.¹³⁰
- Long-term data from state trials in the nation's 75 most populous counties show statistically significant decreases in win rates among medical malpractice plaintiffs. More specifically, the percentage of successful plaintiffs fell by 17 percent from 1996 to 2005 and by 27.7 percent from 2001 to 2005.¹³¹

❖ EXPERTS SAY THAT, EVEN WITH ITS PROBLEMS, THE CURRENT MEDICAL MALPRACTICE SYSTEM WORKS.

**“Could Mandatory Caps on Medical Malpractice Damages Harm Consumers?”
California State University, Northridge Economics Professor and Cato Institute
Adjunct Scholar Shirley Svorny, 2011.**

In an October 2011 study, Professor Svorny analyzed existing empirical data and found that the medical malpractice system works just as it should. As Svorny explained,

- “The medical malpractice system generally awards damages to victims of negligence and fails to reward meritless claims. Plaintiffs’ attorneys, paid on a contingency basis, filter out weak cases. Patients who file valid claims are likely to collect, generally through out-of-court settlements.”¹³²
- “The fact that settlement is common suggests courts are providing good signals as to when plaintiffs will prevail. Under these conditions, insurance companies assess the validity of claims and settle valid claims rather than go to court.”¹³³
- “Critics of the system point to the fact that many initial claims do not involve negligence. This can be explained by patients and their attorneys seeking to gather information about the level of negligence associated with an injury. Once discovery shows a small likelihood of success, many plaintiffs drop their claims.”¹³⁴
- “Critics of the medical malpractice system point to its high administrative costs. ... Yet, as economist Patricia Danzon observes, the bulk of administrative costs are limited to the small fraction of cases that go to court. Meanwhile, the deterrent effect influences all medical practice.”¹³⁵

**“Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,”
Harvard School of Public Health, 2006.**

The closed claims study found that legitimate claims are being paid, non-legitimate claims are generally not being paid and “portraits of a malpractice system that is stricken with frivolous litigation are overblown.”¹³⁶ Among the researchers’ more significant findings:

- Sixty-three percent of the injuries were judged to be the result of error and most of those claims received compensation; on the other hand, most individuals whose claims did not involve errors or injuries received nothing.¹³⁷
- Eighty percent of claims involved injuries that caused significant or major disability or death.¹³⁸
- “[D]isputing and paying for errors account for the lion’s share of malpractice costs.”¹³⁹

❖ THE BEST WAY TO REDUCE MALPRACTICE LITIGATION IS TO REDUCE THE AMOUNT OF MALPRACTICE.

“The Impact of Tort Reform and Quality Improvements on Medical Liability Claims: A Tale of 2 States,” Southern Illinois University Medical School Orthopedic Surgery Division Chief Khaled J. Saleh, M.D., et al., 2015.

A study published in the *American Journal of Medical Quality* linked quality of care improvements with a reduction in medical malpractice claims. Researchers discovered that a “drop in malpractice claims corresponded with an increase in hospitals’ quality scores,” with the decrease in claims showing a “statistically significant correlation with the increase in quality scores based on 22 Medicare measures....” As one of the report’s co-authors explained, “Clearly, the evidence shows that if you do high quality care, it is well received by patients and decreases your medicolegal costs....”¹⁴⁰

“A comprehensive obstetric patient safety program reduces liability claims and payments,” Yale School of Medicine Associate Professor of Obstetric, Gynecology and Reproductive Sciences and Chief of Obstetrics Christian M. Pettker, M.D., et al. 2014.

As reported online by the *American Journal of Obstetrics & Gynecology*, after comparing the five-year period before their patient safety program was implemented to the five-year period afterward (1998-2002 vs. 2003-2007, respectively), Yale School of Medicine researchers found “a strong association between introduction of a comprehensive obstetric patient safety initiative and a dramatic reduction in liability claims and liability payments.” Among their key findings¹⁴¹:

- An estimated 95% reduction in direct liability payments and a savings of \$48.5 million over a 5-year period.
- A “consistent pattern of statistically significant trends in reduced payments and in the variability of these payments.”
- “Furthermore, during this patient safety intervention there was a 53% reduction in liability claims and lawsuits compared with the 5 years prior.”
- “The mean number of annual cases consistently dropped over the 10-year period.”
- There were absolute decreases in the severity and types of cases in each category.
- “The results from this analysis document a third benefit of initiating a comprehensive obstetric patient safety effort: possible cost savings. Although the primary motivations driving patient safety efforts are improving quality of care and eliminating harm, these

data are also important for demonstrating further downstream impacts patient safety projects can have.”

- “A reduction in liability claims is likely a hallmark of an environment with improved quality. In fact, coupling these results with our prior report demonstrating reduced adverse outcomes suggest a direct association, as others have reported.”

“The Association between Patient Safety Indicators and Medical Malpractice Risk: Evidence from Texas,” Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black and Northwestern University Department of Economics Ph.D. Candidate Zenon Zabinski, 2013.

- After studying Texas data on medical malpractice claims closed between 1988 and 2010,¹⁴² researchers found that “higher rates of adverse patient safety events predict higher rates of paid med mal risk claims. This suggests that med mal suits – at least the suits that lead to paid claims – are not random, and that hospitals can reduce their med mal risk by improving patient safety.”¹⁴³ The authors conclude:

If hospitals can reduce adverse events at reasonable cost – as they apparently can, since some do so – why don’t they? Mello and Studdert (2007) find that hospitals are largely insulated from the financial costs associated from patient injuries, including those due to negligence. Krupka, Sandberg, and Weeks (2012) report that hospitals earn substantially higher revenue when surgical patients suffer complications than when they do not. O’Connor (2012) reports that only about 1% of hospitals have installed inexpensive sponge-tracking systems, which could reduce PSI 5 (Foreign Body Left during Procedure) rates to nearly zero. Writ large, the financial incentives for increasing patient safety, including those provided by med mal liability, are weak.¹⁴⁴

Is Better Patient Safety Associated with Less Malpractice Activity? Evidence from California, Rand Institute for Civil Justice, 2010.

- “Our results showed a highly significant correlation between the frequency of adverse events and malpractice claims: On average, a county that shows a decrease of 10 adverse events in a given year would also see a decrease of 3.7 malpractice claims. Likewise, a county that shows an increase of 10 adverse events in a given year would also see, on average, an increase of 3.7 malpractice claims. According to the statistical analysis, nearly three-fourths of the within-county variation in annual malpractice claims could be accounted for by the changes in patient safety outcomes.”¹⁴⁵
- “We also found that the correlation held true when we conducted similar analyses for medical specialties—specifically, surgeons, nonsurgical physicians, and obstetrician/gynecologists (OB-GYNs). Nearly two-thirds of the variation in malpractice claiming against surgeons and nonsurgeons can be explained by changes in safety. The association is weaker for OB-GYNs, but still significant.”¹⁴⁶

- “These findings are consistent with the basic hypothesis that iatrogenic harms are a precursor to malpractice claims, such that modifying the frequency of medical injuries has an impact on the volume of litigation that spills out of them. Although this is an intuitive relationship, it is not one that has been well validated previously. It suggests that safety interventions that improve patient outcomes have the potential to reduce malpractice claiming, and in turn, malpractice pressure on providers.”¹⁴⁷
- “[N]ew safety interventions potentially can have positive effects on the volume of malpractice litigation — a desirable result to seek out, even beyond the immediate impact of medical injuries avoided.”¹⁴⁸
- “Presumably, the one thing that all parties to the debate can agree on is that reducing malpractice activity by reducing the number of iatrogenic injuries is a good idea. Arguments about the merits of statutory tort intervention will surely continue in the future, but to the extent that improved safety performance can be shown to have a demonstrable impact on malpractice claims, that offers another focal point for policymakers in seeking to address the malpractice crisis. Based on the results of the current study, we would suggest that that focal point may be more immediately relevant than has previously been recognized.”¹⁴⁹

PART 2: MEDICAL MALPRACTICE, HEALTH CARE COSTS AND “DEFENSIVE MEDICINE”

❖ NUMEROUS STUDIES HAVE DEBUNKED THE NOTION THAT HEALTH CARE COSTS CAN BE SAVED BY STRIPPING AWAY PATIENTS’ LEGAL RIGHTS; “TORT REFORM” HAS NO IMPACT ON SO-CALLED DEFENSIVE MEDICINE.

“Are chargemaster rates for imaging studies lower in States that cap noneconomic damages (tort reform)?” Temple University Medical School Radiologist Seth I. Stein, M.D., et al, 2014.

Imaging costs did not drop in states with med mal non-economic damages (NED) caps.¹⁵⁰ In fact, “imaging costs in some of the states that cap NED payouts were among the highest in the nation.”¹⁵¹ For example, “California, a state with NED tort reform, was ranked among the most costly for imaging”¹⁵²; “the \$662 mean charge in California for a level I diagnostic and screening ultrasound was 36 percent higher than that for all states.”¹⁵³ In addition, “[o]ver the past decade, imaging charges in California have increased by 400 percent, they noted, despite the NED tort reform.”¹⁵⁴ Similarly, Florida and Nevada, also “NED-capped states,” have experienced high imaging costs.¹⁵⁵

“The Effect of Malpractice Reform on Emergency Department Care,” RAND Corporation Adjunct Natural Scientist Daniel A. Waxman, M.D., Ph.D., et al., 2014.

After examining 3.8 million Medicare patient records from 1,166 hospital emergency departments from 1997 to 2011 – comparing care in three states before and after they changed their emergency care standard to gross negligence with care in neighboring states that did not pass malpractice reform – researchers found that raising the legal standard for malpractice did not result in less expensive care.¹⁵⁶

As explained in an October 15, 2014 RAND press release, the study “examined whether physicians ordered an advanced imaging study (CT or MRI scan), whether the patient was hospitalized after the emergency visit and total charges for the visit. Advanced imaging and hospitalization are among the most costly consequences of an emergency room visit, and physicians themselves have identified them as common defensive medicine practices.”¹⁵⁷ The researchers discovered that “malpractice reform laws had no effect on the use of imaging or on the rate of hospitalization following emergency visits. For two of the states, Texas and South Carolina, the law did not appear to cause any reduction in charges. Relative to neighboring states, Georgia saw a small drop of 3.6 percent in average emergency room charges following its 2005 reform.”¹⁵⁸

“Our findings suggest that malpractice reform may have less effect on costs than has been projected by conventional wisdom,” said Dr. Daniel A. Waxman, the study’s lead author. “Physicians say they order unnecessary tests strictly out of fear of being sued, but our results suggest the story is more complicated. . . . This study suggests that even when the risk of being sued for malpractice decreases, the path of least resistance still may favor resource-intensive care, at least in hospital emergency departments. . . .”¹⁵⁹

“Do Doctors Practice Defensive Medicine, Revisited,” Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black et al., 2014.

The authors examined health care spending trends in nine states that enacted caps during the last “hard” insurance market (2002 to 2005)¹⁶⁰ and compared these data to other “control” states. They found that “damage caps have no significant impact on Medicare Part A (hospital) spending, but lead to 4-5% *higher* Medicare Part B (physician) spending” [emphasis in the original].¹⁶¹ As the researchers note:

“Damage caps have long been seen by health policy researchers and policymakers as a way to control healthcare costs. We find, in contrast, no evidence that adoption of damage caps or other changes in med mal risk will reduce healthcare spending. Instead, we find evidence that states which adopted during the third wave of med mal reforms have *higher* post-cap Medicare Part B spending. . . .” [emphasis in the original].¹⁶²

“[O]ne policy conclusion is straightforward: There is no evidence that limiting med mal lawsuits will bend the healthcare cost curve, except perhaps in the wrong direction. Policymakers seeking a way to address rising healthcare spending should look elsewhere.”¹⁶³

“The Relationship Between Tort Reform and Medical Utilization” Health Watch USA Chair Kevin T. Kavanagh, M.D., M.S. et al., 2013.

“The comparison of the Dartmouth Atlas Medicare Reimbursement Data with Malpractice Reform State Rankings, which are used by the PRI [Pacific Research Institute], did not support the hypothesis that defensive medicine is a driver of rising health-care costs. Additionally, comparing Medicare reimbursements, premedical and postmedical tort reform, we found no consistent effect on health-care expenditures. Together, these data indicate that medical tort reform seems to have little to no effect on overall Medicare cost savings.”¹⁶⁴

“Will Tort Reform Bend the Cost Curve? Evidence from Texas,” Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black et al., 2012.

In June 2012, the *Journal of Empirical Legal Studies* published a groundbreaking study, which concluded that limiting injured patients’ legal rights will not reduce overall health-care spending.¹⁶⁵ Professor Black and his co-authors – David A. Hyman, University of

Illinois College of Law; Myungho Paik, Northwestern University Law School; and Charles Silver, University of Texas Law School – examined Medicare spending after Texas enacted severe “tort reform” in medical malpractice cases, including “caps” on compensation for injured patients, and found no evidence of a decline in health-care utilization. Among the report’s key findings:

Texas’s “Tort Reforms” Did Not Reduce Health-Care Spending Or Spending Trends.

- “A major exogenous shock to med mal risk from the reforms had no material impact on Medicare spending (in effect, health-care quantity), no matter how we slice the data.”¹⁶⁶
- “We find no evidence that overall health-care spending, physician spending, or imaging and lab spending declined more in counties with higher med mal risk.”¹⁶⁷
- “We also find no overall decline in Texas Medicare spending relative to control states, nor an overall association between spending (or spending trends) and med mal risk.”¹⁶⁸
- “If anything, we find some evidence, well short of definitive, that physician spending rose after reform in larger, high-risk counties.”¹⁶⁹
- “Our data are limited to Medicare, but med mal reform seems even less likely to influence treatment intensity for the privately insured, since most private insurers exercise greater oversight over treatment decisions than does Medicare.”¹⁷⁰
- “The further one gets from the time of reform, the less reliable will be any effort to have confidence in a causal link between tort reform and health-care spending.”¹⁷¹

Limiting Patients’ Rights Will Have Little Impact On Health-Care Spending.

- “Our results, combined with those from other studies, let us place some bounds on the likely impact of tort reform on spending. We believe a ‘credible interval’ for the most likely effect of major tort reform on health-care spending runs from 0 percent to about a 2 percent decline for states that currently lack caps on non-econ or total damages.”¹⁷²
- “Zero to one percent of health-care spending is \$0 to \$30 billion per year. The upper end of this range is more than small change, but we believe that claims that tort reform can meaningfully bend the health-care cost curve, or save hundreds of billions of dollars in annual spending, are not plausible, based on the available research.”¹⁷³
- “Higher spending cannot be ruled out; indeed, our study finds some evidence suggesting higher spending after reform.”¹⁷⁴

There Are Many Reasons Why “Tort Reform” Doesn’t Lower Health-Care Spending.

- “One possibility is that there may not be much ‘pure’ defensive medicine – medical treatments driven solely by liability risk. If liability is only one of a number of factors that influence clinical decisions, even a large reduction in med mal risk might have little impact on health-care spending.”¹⁷⁵
- “Lower med mal risk could lead some doctors to practice less defensive medicine, yet make other doctors more willing to offer aggressive medical treatment that is profitable to the doctor but of doubtful value to the patient.”¹⁷⁶
- “There could be savings in some areas of medical practice (cardiac care, perhaps), yet higher costs in other areas. The physician tendency toward more aggressive treatment as med mal risk declines might be stronger in urban areas, with more sophisticated physicians. This could explain the hints we find of higher physician spending in these areas.”¹⁷⁷
- “[I]f the major, highly publicized Texas reforms, followed by a major drop in insurance premiums, did little to persuade doctors to practice less defensively, it is unclear what would do so, other than complete abolition of med mal liability. To date, no one has proposed going that far.”¹⁷⁸

Countless Explanations Exist As To Why U.S. Health Care Costs Are Out Of Control.

- “One is physician incentives to provide profitable services....A second is a political system that has thus far been unwilling to impose, for the publicly financed portion of health-care spending, the types of limits on spending that are routine in many other countries.”¹⁷⁹
- Moreover, “[p]olitically convenient myths are hard to kill. The myth that defensive medicine is an important driver of health-care costs is convenient to politicians who claim to want to control costs, but are unwilling to take the unpopular (with physicians or the elderly) steps needed to do so. It is convenient for health-care providers, who prefer lower liability risk. It is also convenient for members of the public, who find it easy to blame lawyers and the legal system for problems that have more complex and difficult roots, and call for stronger responses.”¹⁸⁰

“The Empirical Effects of Tort Reform,” Cornell University Law School Professor Theodore Eisenberg, 2012.

“Tort reform” provides little in the way of health care savings: “One recent summary concludes that the ‘accumulation of recent evidence finding zero or small effects suggests that it is time for policymakers to abandon the hope that tort reform can be a major element in healthcare cost control’ (Paik 2012, 175).”¹⁸¹

True Risk: Medical Liability, Malpractice Insurance And Health Care, Americans for Insurance Reform, 2009.

“In over 30 years, medical malpractice premiums and claims have never been greater than 1% of our nation’s health care costs.”¹⁸²

CBO’s Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice (“Tort Reform”), Congressional Budget Office, 2009

The Congressional Budget Office (CBO), in its October 2009 analysis (in the form of a 7-page letter to Senator Orin Hatch),¹⁸³ found that even if the country enacted an entire menu of extreme tort restrictions, it could go no farther than to find an extremely small percentage of health care savings, about 0.5%, “far lower than advocates have estimated.”¹⁸⁴ This includes even smaller health care savings – “0.3 percent from slightly less utilization of health care services”¹⁸⁵ or “defensive medicine.” CBO ignored factors that would not only lower this already small figure but also likely *increase* costs:

- “CBO acknowledged but did not consider in its cost calculations the fact that these kinds of extreme “tort reforms” would weaken the deterrent potential of the tort system, with accompanying increases in cost and physician utilization inherent in caring for newly maimed patients and for care.”¹⁸⁶
- “There will be new burdens on Medicaid because if someone is brain damaged, mutilated or rendered paraplegic as a result of the medical negligence but cannot obtain compensation from the culpable party through the tort system (which is the impact of capping even non-economic damages), he or she may be forced to turn elsewhere for compensation, particularly Medicaid. None of these increased Medicaid costs are considered.”¹⁸⁷
- “Whenever there is a successful medical malpractice lawsuit, Medicare and Medicaid can both claim either liens or subrogation interests in whatever the patient recovers, reimbursing the government for some of the patients’ health care expenditures. Without the lawsuit, Medicare and Medicaid will lose funds that the government would otherwise be able to recoup. Again, none of these lost funds are factored in by the CBO.”¹⁸⁸
- “CBO arrived at its numbers by plugging selective studies into CBO’s internal econometric models that no one ever sees. When Senator Jay Rockefeller (D-WV) asked CBO for a “complete empirical analysis of the cost savings associated with medical malpractice reforms,” CBO’s response was another seven-page letter. No empirical analysis, no econometric models and no data were provided.”¹⁸⁹

The Truth About Torts: Defensive Medicine and the Unsupported Case for Medical Malpractice 'Reform,' Center for Progressive Reform, 2012.

“The evidence reveals that ‘defensive medicine’ is largely a myth, proffered by interests intent on limiting citizen access to the courts for deserving cases, leaving severely injured patients with no other recourse for obtaining the corrective justice they deserve. These changes would limit the deterrent effect of civil litigation and diminish the regulatory backstop that the civil justice system provides to the professional licensing system, leading to more medical errors.

...

“What is perhaps most striking about the CBO letter, though, is the rare departure from years of careful analysis. The CBO’s past work found small savings from civil justice restrictions and declared the evidence on ‘defensive medicine’ to be ‘weak or inconclusive’ and ‘at best ambiguous.’ Another CBO report, in 2004, described the limits of Kessler and McClellan’s 1996 Medicare research by concluding, ‘those studies were conducted on a restricted sample of patients, whose treatment and behavior cannot be generalized to the population as a whole.’ In fact, just ten months before its letter to Senator Hatch, the CBO concluded that there is insufficient evidence that civil justice restrictions would reduce health care costs. The past work speaks for itself. Little changed in the research on defensive medicine in the years between CBO’s prior analyses and its letter to Senator Hatch.”¹⁹⁰

“Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussions,” Columbia University Mailman School of Public Health Clinical Professor Fred Hyde, M.D., 2011.¹⁹¹

- “‘Defensive medicine’ by all accounts has become such a myth, a combination of surveys of interested parties and the ‘imagination’ that those parties are avoiding – or believe they are avoiding – liability through alteration of their medical practices.”
- “The cost, if any, of defensive medicine, are trivial, in comparison to the cost of health care.”
- Medical liability “acts as a guardian against under treatment, the primary concern which should now be facing policy-makers.”
- “If tort reform reduces or even eliminates sanctions associated with negligent care and activity, adverse events themselves may increase, and by a number far greater than .2, .3 or .7% of the American health care bill.”
- “The implicit hypothesis would appear to be the following: That, in contravention of good medical judgment, the basic rules of Medicare (payment only for services that are medically necessary), threats of the potential for False Claim Act (prescribing, referring,

where medically unnecessary), physicians will, as a group, act in ways which are possibly contrary to the interests of their patients, certainly contrary to reimbursement and related rules, under a theory that excessive or unnecessary prescribing and referring will insulate them from medical liability. There are many more cases concerning incompetence in credentialing and privileging, negligent referral, unnecessary radiation, etc., to provide at least a counter hypothesis.”

- “[A]s reaffirmed in the CBO studies, and as reflected in the literature generally, all estimates of the ‘indirect’ costs of professional liability, including, for example, the cost, if any, of defensive medicine, are trivial, in comparison to the cost of health care. Controversies involving Senators, the CBO in 2009 appear entirely to reflect the difference between .2 and .5% of health costs.”
- “The import of the phrase ‘defensive medicine’ is in its ‘political’ or strategic use: ‘Defensive medicine has mainly been invoked as an argument for tort reform in the years between malpractice crises when other pressures for legal change have ebbed.’ The methods used to study the existence, prevalence and impact of defensive medicine have been, primarily, survey of those (practicing physicians) who may be perceived as having a position or stance in the political discussion, in addition to having access to information necessary to answer the questions posed above.”
- “Survey-type findings led to a conclusion that defensive medicine was significant among physicians in Pennsylvania who pay the most for liability insurance. In later studies (Mello [footnote omitted]), however, some of the same authors have cast doubt on the survey as an objectively verifiable means of establishing the presence, quantity or scope of defensive medicine.”
- “The fee for service system both empowers and encourages physicians to practice very low risk medicine. Health care reform may change financial incentives toward doing fewer rather than more tests and procedures. If that happens, concerns about malpractice liability may act to check potential tendencies to provide too few services.”
- “If most claims result from errors, and most errors result in injuries, and most injuries resulting from such errors result in compensation (73%), what is at stake in limiting access to the courts? If access is limited, it would be in recognition that the basic principle of civil justice, having a remedy available to enforce a right, is void.”

Defensive Medicine and Medical Malpractice, Office of Technology Assessment, 1994.

The congressional office found that less than 8 percent of all diagnostic procedures were likely to be caused primarily by liability concerns. According to its analysis, 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.” The effects of “tort reform” on defensive medicine “are likely to be small.”¹⁹²

❖ STUDIES ESTABLISHING “DEFENSIVE MEDICINE” DEPEND ALMOST ENTIRELY ON UNTRUSTWORTHY PHYSICIAN SURVEYS, OFTEN CONCEIVED BY LOBBY GROUPS PUSHING “TORT REFORM.”

“Critique of February 2011 AAOS ‘Defensive Medicine’ Survey,” Columbia University Mailman School of Public Health Clinical Professor Fred Hyde, M.D., 2011.

In a widely-reported recent “survey” of 56¹⁹³ or 72¹⁹⁴ Pennsylvania orthopedic surgeons, respondents claim that 19.7 percent of the imaging tests they ordered were for defensive purposes – *i.e.* to avoid being sued. This supposedly amounts to 34.8 percent of total imaging costs because “the most common test was an MRI, an imaging test which costs more than a regular X-ray.”¹⁹⁵ Professor Hyde reviewed this study for CJ&D and found:

- “In searching for the actual paper containing these findings, it turns out that there is no paper, much less one peer reviewed prior to publication. Instead, this was a podium presentation by a medical student, accompanied by a faculty supervisor.”¹⁹⁶
- “The methodology, according to news and public relations reports, was this: to ask the ordering doctor whether or not he or she was ordering a test for reasons having to do with ‘defensive medicine.’”¹⁹⁷
- “However, the issues are not straightforward. For example, a moderator of the presentation suggested other possible explanations for the MRI exams. He noted that MRIs and other imaging studies are frequently ordered ‘unnecessarily’ for reasons *other than malpractice avoidance*.
 - “The moderator noted that many MRIs are required by insurers before those insurers will authorize an arthroscopy (a minimally invasive surgical procedure in which an examination and treatment of damage of the interior of a joint is performed using an arthroscope, an endoscope inserted into the joint through a small incision).
 - “The insurers require the imaging study in an attempt to protect against fraud. Orthopedic surgeons believe the MRI study prior to arthroscopy to be unnecessary; this was affirmed by a show of hands in the audience for the San Diego presentation.”¹⁹⁸
- “No mention was made of the potential for fraudulent billing if the MRI studies ordered were not for the benefit of the patient. If the box checked ‘defensive’ were accompanied by a box that indicated ‘no bill to be rendered’ or ‘bill referring physician’ this would undoubtedly have been included in the report. It would be a reasonable assumption that, to the contrary, a bill was rendered to the patient or to the insurance company for the MRIs as ordered. Were the physicians really uninterested in the results of the MRI tests, and willing to risk sanction? Or

did they ‘check the box’ to ‘show support’ without realizing that it might indicate a potentially fraudulent act?”¹⁹⁹

- “Appearing in Pennsylvania especially, this study should be regarded primarily as an advocacy position. This advocacy presentation has received disproportionate attention due to its timing in the context of current proposals before the Congress, not because of the credibility of the survey. The difficulty facing physicians especially in Pennsylvania concerning the cost and availability of malpractice insurance are well known, but are due to insurance issues, and not to causes directly related to tort law.”²⁰⁰

Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care, General Accountability Office, 2003.

The General Accountability Office (GAO) condemned the use of “defensive medicine” physician surveys as being inaccurate and misleading.²⁰¹ The GAO also noted that those who produced and cited such surveys “could not provide additional data demonstrating the extent and costs associated with defensive medicine.”²⁰² And, “some officials pointed out that factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures”²⁰³ and “according to some research, managed care provides a financial incentive not to offer treatments that are unlikely to have medical benefit.”²⁰⁴

❖ DEFENSIVE MEDICINE IS MEDICARE FRAUD.

A doctor who bills Medicare or Medicaid for tests and procedures done for a personal purpose – *e.g.*, possible lawsuit protection – as opposed to what is medically necessary for a patient, is committing fraud under federal and state Medicare/Medicaid programs.

- The Medicare law states: “It shall be the obligation of any health care practitioner and any other person...who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act...will be provided economically and only when, and to the extent, medically necessary.”²⁰⁵ “[N]o payment may be made under part A or part B for any expenses incurred for items or services...which...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”²⁰⁶
- Providers cannot be paid and/or participate in the Medicare program unless they comply with these provisions, and they impliedly certify compliance with these provisions when they file claims. Thus, if they are not in compliance, the certifications and the claims are false. Providers who do not comply and/or file false claims can be excluded from the Medicare program.²⁰⁷
- Perhaps more importantly, the Medicare claim form (Form 1500) requires providers to expressly certify that “the services shown on the form were medically indicated and necessary for the health of the patient.”²⁰⁸ If the services are, to the doctor’s knowledge, not medically necessary, the claim is false.

❖ THE REAL REASONS DOCTORS MAY ORDER TOO MANY TESTS AND PROCEDURES: WORKLOAD AND REVENUE.

“Service Intensity and Physician Income: Conclusions From Medicare's Physician Data Release,” UCLA Medical School Urology and Family Medicine Assistant Professor Jonathan Bergman, M.D., M.P.H., et al., 2014.

Review of 2012 Medicare data showed that “higher-earning clinicians make more money by ordering more procedures and services per patient rather than by seeing more patients, which may not be in patients’ best interest.”²⁰⁹ According to the study’s lead author, “These findings suggest that the current health care reimbursement model – fee-for-service – may not be creating the correct incentives for clinicians to keep their patients healthy.”²¹⁰

“Impact of Attending Physician Workload on Patient Care: A Survey of Hospitalists,” Johns Hopkins Assistant Professor of Medicine Henry J. Michtalik, M.D., M.P.H., M.H.S., et al., 2013.

In a survey of hospital attending doctors published in *JAMA Internal Medicine*, 22 percent of physicians reported that workload led them to “order potentially unnecessary tests, procedures, consultations, or radiographs due to not having the time to assess the patient adequately in person.”²¹¹ In other words, a heavy workload, not fear of lawsuits, caused them to order extra tests, etc.

“Exclusive: Medicare on drugs: 24,000 tests for 145 patients,” Reuters, May 29, 2014.

“Medicare paid medical providers \$457 million in 2012 for 16 million tests to detect everything from prescription narcotics to cocaine and heroin, according to the Reuters analysis. ‘In some parts of the country every doctor and his cousin is hanging out a shingle to do (addiction) treatment. There’s a tailor-made opportunity for ordering a profusion of tests instead of one,’ said Bill Mahon, former executive director of the National Health Care Anti-Fraud Association. ‘It’s like turning on a spigot of money,’ he said.”²¹²

“Doctors Overlook Lucrative Procedures When Naming Unwise Treatments,” Chicago Tribune and Kaiser Health News, April 14, 2014.

- “The medical profession has historically been reluctant to condemn unwarranted but often lucrative tests and treatments that can rack up costs to patients but not improve their health and can sometimes hurt them.”²¹³
- In 2012, “medical specialty societies began publishing lists of at least five services that both doctors and patients should consider skeptically. ... Yet some of the largest medical associations selected rare services or ones that are done by practitioners in other fields

and will not affect their earnings. ‘They were willing to throw someone else’s services into the arena, but not their own,’ said Dr. Nancy Morden, a researcher at the Dartmouth Institute for Health Policy & Clinical Practice in New Hampshire.”²¹⁴

- The American College of Cardiology “did not tackle what studies suggest is the most frequent type of overtreatment in the field: inserting small mesh tubes called stents to prop open arteries of patients who are not suffering heart attacks, rather than first prescribing medicine or encouraging a healthier lifestyle. As many as one out of eight of these stent procedures should not have been performed, according to a study in *Circulation*, the journal of the American Heart Association. At hospitals where stenting was most overused, 59 percent of stents were inappropriate, the study found.”²¹⁵
- “Dr. Augusto Sarmiento, a former president of the academy and retired chairman of orthopedics at the University of Miami Miller Medical School, said there were more significant overused procedures the academy omitted, including replacing hips and knees when the patient’s pain is minimal and can be managed with medicine. In addition, Sarmiento said too many surgeons operate on simple fractured collarbones, inserting metal plates, rather than letting the injury heal with the help of a sling.”²¹⁶

“Patients’ Costs Skyrocket; Specialists’ Incomes Soar,” *New York Times*, January 19, 2014.

- “Doctors’ charges – and the incentives they reflect – are a major factor in the nation’s \$2.7 trillion medical bill. Payments to doctors in the United States, who make far more than their counterparts in other developed countries, account for 20 percent of American health care expenses, second only to hospital costs.”²¹⁷
- “Many specialists have become particularly adept at the business of medicine by becoming more entrepreneurial, protecting their turf through aggressive lobbying by their medical societies, and most of all, increasing revenues by offering new procedures – or doing more of lucrative ones.”²¹⁸
- “In addition, salary figures often understate physician earning power since they often do not include revenue from business activities: fees for blood or pathology tests at a lab that the doctor owns or ‘facility’ charges at an ambulatory surgery center where the physician is an investor, for example.”²¹⁹

“What’s the deal with health care credit cards? Four things you should know” and “CFPB Orders GE CareCredit to Refund \$34.1 Million for Deceptive Health-Care Credit Card Enrollment,” U.S. Consumer Financial Protection Bureau, 2013 and 2014.

- “Recently, many patients facing medical procedures have seen their health care providers suggest deferred interest rate credit cards as a payment option. Unfortunately, health care providers don’t always explain how these deferred interest credit cards work. ...Case in point: GE CareCredit cards.”²²⁰

- “CareCredit offers personal lines of credit for health-care services, including dental, cosmetic, vision, and veterinary care. Doctors, dentists and other medical providers and their office staff, such as office managers and receptionists, are the primary sellers of the product, offering it as a payment option for their patients. The product is sold by more than 175,000 enrolled providers across the country. There are about 4 million active CareCredit cardholders.”²²¹
- In December 2013, the Consumer Financial Protection Bureau ordered GE Capital Retail Bank and its subsidiary, CareCredit, to “refund up to \$34.1 million to potentially more than 1 million consumers who were victims of deceptive credit card enrollment tactics. At doctors’ and dentists’ offices around the country, consumers were signed up for CareCredit credit cards they thought were interest free, but were actually accruing interest that kicked in if the full balance was not paid at the end of a promotional period. According to the CFPB order, since January 2009, consumers who signed up for the credit card frequently received an inadequate explanation of the terms. Many consumers, most of whom were enrolled while waiting for health-care treatment, incurred substantial debt because they did not understand how they could have avoided deferred interest, penalties, and fees.”

Darshak Sanghavi, M.D., Chief of Pediatric Cardiology at the University of Massachusetts Medical School, 2013.

“Studies show that doctors order a lot of questionable testing and treatment even when malpractice risks are very low.”²²²

“Deaths Linked to Cardiac Stents Rise as Overuse Seen,” *Bloomberg News*, 2013.

- For the nearly 350,000 elective-surgery patients in stable condition who have cardiac stents implanted each year, “overuse, death, injury and fraud have accompanied the devices’ use as a go-to treatment...”²²³ This was the finding of a *Bloomberg News* investigation, which examined “thousands of pages of court documents and regulatory filings, interviews with 37 cardiologists and 33 heart patients or their survivors, and more than a dozen medical studies.”²²⁴ According to the report, “These sources point to stent practices that underscore the waste and patient vulnerability in a U.S. health care system that rewards doctors based on volume of procedures rather than quality of care. Cardiologists get paid less than \$250 to talk to patients about stents’ risks and alternative measures, and an average of four times that fee for putting in a stent.”²²⁵
- ““Stenting belongs to one of the bleakest chapters in the history of Western medicine,”” University of North Carolina at Chapel Hill’s Professor Nortin Hadler told *Bloomberg News*.²²⁶ “Cardiologists ‘are marching on’ because ‘the interventional cardiology industry has a cash flow comparable to the GDP of many countries’ and doesn’t want to lose it, he said.”²²⁷ Former Assistant U.S. Attorney Jamie Bennett echoed these sentiments: ““There is a huge financial incentive to increase the number of these procedures....The cases we

have seen to date are just the tip of the iceberg.” As of September 26, 2013, “[a]t least five hospitals have reached settlements with the Justice Department over allegations that they paid illegal kickbacks to doctors for patient referrals to their cath labs.”²²⁸

Spinal Devices Supplies by Physician-Owned Distributors: Overview of Prevalence and Use, Office of Inspector General, U.S. Department of Health and Human Services, 2013.

Responding to a congressional request to investigate the growth of physician-owned distributorships for spinal fusion equipment (screws, rods and plates) and their impacts on Medicare beneficiaries and federal health care programs, OIG studied Medicare billings and found that “financial incentives for doctors may be driving some of the rapid rise in spinal fusion surgery.”²²⁹ Among the data uncovered, as reported by the *Washington Post*:

- “Nearly one in five spinal fusions sampled in the study involved equipment purchased from distributors that were co-owned by physicians”;
- “Six months after a hospital began to purchase spinal devices from a physician-owned distributorship, the number of spinal fusions performed jumped 21 percent on average, more than twice as fast as at other hospitals”;
- “Doctors who are investors in such companies stand to benefit when more spinal fusions are performed”; and
- “The average hospital performed 62 spinal fusion surgeries per 1,000 surgical patients before beginning to purchase devices from the physician-owned companies; that figure climbed to 75 spinal surgeries per 1,000 surgical patients afterward.”

After reviewing the study, Sen. Orrin G. Hatch (R-Utah), the ranking member of the Senate Finance Committee, which had requested the investigation, said, “With this report, HHS’s inspector general has produced data that clearly demonstrate a direct correlation between the perverse financial incentives created by physician-owned distributorships and the rise in these highly invasive spinal surgeries.... Given the impact of these surgeries on seniors and their health, the structure of these entities needs to be further scrutinized.”²³⁰

Medicare: Higher Use of Costly Prostate Cancer Treatment by Providers Who Self-Refer Warrant Scrutiny, U.S. Government Accountability Office, 2013.

The report, requested by bipartisan leaders in Congress, found that doctors whose practices offered IMRT – an intensive form of prostate cancer treatment that usually costs over \$31,000 – were more likely to refer patients for IMRT therapy than less expensive treatments.²³¹ More specifically,²³²

- “The number of Medicare prostate cancer-related intensity-modulated radiation therapy (IMRT) services performed by self-referring groups increased rapidly, while declining for non-self-referring groups from 2006 to 2010.”
- “Over this period, the number of prostate cancer–related IMRT services performed by self-referring groups increased from about 80,000 to 366,000. Consistent with that growth, expenditures associated with these services and the number of self-referring groups also increased.”
- “Providers substantially increased the percentage of their prostate cancer patients they referred for IMRT after they began to self-refer. Providers that began self-referring in 2008 or 2009 – referred to as switchers – referred 54 percent of their patients who were diagnosed with prostate cancer in 2009 for IMRT, compared to 37 percent of their patients diagnosed in 2007. In contrast, providers who did not begin to self-refer – that is, non-self-referrers and providers who self-referred the entire period – experienced much smaller changes over the same period.”
- “Among all providers who referred a Medicare beneficiary diagnosed with prostate cancer in 2009, those that self-referred were 53 percent more likely to refer their patients for IMRT and less likely to refer them for other treatments, especially a radical prostatectomy or brachytherapy. Compared to IMRT, those treatments are less costly and often considered equally appropriate but have different risks and side effects.”
- “Factors such as age, geographic location, and patient health did not explain the large differences between self-referring and non-self-referring providers. These analyses suggest that financial incentives for self-referring providers – specifically those in limited specialty groups – were likely a major factor driving the increase in the percentage of prostate cancer patients referred for IMRT.”
- “Medicare providers are generally not required to disclose that they self-refer IMRT services, and the Department of Health and Human Services (HHS) lacks the authority to establish such a requirement. Thus, beneficiaries may not be aware that their provider has a financial interest in recommending IMRT over alternative treatments that may be equally effective, have different risks and side effects, and are less expensive for Medicare and beneficiaries.”
- “To the extent that providers’ financial interests are shaping treatment decisions, some patients may end up on a treatment course that does not best meet their individual needs. Second, because IMRT costs more than most other treatments, the higher use of IMRT by self-referring providers results in higher costs for Medicare and beneficiaries. To the extent that treatment decisions are driven by providers’ financial interest and not by patient preference, these increased costs are difficult to justify.”

**“Urologists' Use of Intensity-Modulated Radiation Therapy for Prostate Cancer,”
Georgetown University Public Policy Institute Economist and Professor Jean M.
Mitchell, PhD., 2013.**

According to a comprehensive study financed by the American Society for Radiation Oncology (ASTRO) and published in the *New England Journal of Medicine*, doctors who have a financial interest in [intensity-modulated radiation therapy] IMRT are twice as likely to recommend it despite the absence of strong evidence that it would be better than less costly options.²³³ As reported by *Reuters*, “Federal law prohibits what is known as self-referral, when doctors send patients for tests or treatment from which the physician stands to gain financially, but makes an exception for ‘in house’ services.”²³⁴ Yet, “urologists are taking advantage of a loophole in federal law that doesn’t make it a conflict of interest for the doctors to benefit from such an arrangement,” the study’s author told *Reuters*.²³⁵ ASTRO’s Chairwoman agreed, saying in a news release that the “study provides clear, indisputable evidence that many men are receiving unnecessary radiation therapy for their prostate cancer due to self-referral,” adding that “[w]e must end physician self-referral for radiation therapy and protect patients from this type of abuse.”²³⁶

Medicare: Action Needed to Address Higher Use of Anatomic Pathology Services by Providers Who Self-Refer, U.S. Government Accountability Office, 2013.

- “Self-referred anatomic pathology services increased at a faster rate than non-self-referred services from 2004 to 2010. During this period, the number of self-referred anatomic pathology services more than doubled, growing from 1.06 million services to about 2.26 million services, while non-self-referred services grew about 38 percent, from about 5.64 million services to about 7.77 million services.”
- “Similarly, the growth rate of expenditures for self-referred anatomic pathology services was higher than for non-self-referred services. Three provider specialties – dermatology, gastroenterology, and urology – accounted for 90 percent of referrals for self-referred anatomic pathology services in 2010.”
- “Referrals for anatomic pathology services by dermatologists, gastroenterologists, and urologists substantially increased the year after they began to self-refer. Providers that began self-referring in 2009 – referred to as switchers – had increases in anatomic pathology services that ranged on average from 14.0 percent to 58.5 percent in 2010 compared to 2008, the year before they began self-referring, across these provider specialties. In comparison, increases in anatomic pathology referrals for providers who continued to self-refer or never self-referred services during this period were much lower. Thus, the increase in anatomic pathology referrals for switchers was not due to a general increase in use of these services among all providers.”

- “GAO’s examination of all providers that referred an anatomic pathology service in 2010 showed that self-referring providers of the specialties we examined referred more services on average than non-self referring providers. Differences in referral for these services generally persisted after accounting for geography and patient characteristics such as health status and diagnosis. These analyses suggest that financial incentives for self-referring providers were likely a major factor driving the increase in referrals.”
- “GAO estimates that in 2010, self-referring providers likely referred over 918,000 more anatomic pathology services than if they had performed biopsy procedures at the same rate as and referred the same number of services per biopsy procedure as non-self-referring providers. These additional referrals for anatomic pathology services cost Medicare about \$69 million. To the extent that these additional referrals were unnecessary, avoiding them could result in savings to Medicare and beneficiaries, as they share in the cost of services.”

“Physician Self-Referral: Frequency of Negative Findings at MR Imaging of the Knee as a Marker of Appropriate Utilization,” Duke University Medical Center Radiology Fellow Matthew P. Lungren, M.D. et al., 2013.

After reviewing 700 referrals for knee M.R.I.s made by two physician groups (one with a financial interest in the machine, the other without), researchers found that “patients are more likely to have magnetic resonance imaging scans that indicate nothing is wrong if they are referred by a doctor who owns the machine. The scientists conclude that doctors with a financial interest in the machines may be more likely to order M.R.I.s even when clinical findings suggest they are unnecessary.”²³⁷

“Patients Mired in Costly Credit From Doctors,” *New York Times*, October 13, 2013.

- “In dentists’ and doctors’ offices, hearing aid centers and pain clinics, American health care is forging a lucrative alliance with American finance. A growing number of health care professionals are urging patients to pay for treatment not covered by their insurance plans with credit cards and lines of credit that can be arranged quickly in the provider’s office. The cards and loans, which were first marketed about a decade ago for cosmetic surgery and other elective procedures, are now proliferating among older Americans, who often face large out-of-pocket expenses for basic care that is not covered by Medicare or private insurance.”²³⁸
- “While medical credit cards resemble other credit cards, there is a critical difference: they are usually marketed by caregivers to patients, often at vulnerable times, such as when those patients are in pain or when their providers have recommended care they cannot readily afford.”²³⁹
- “Many of these cards initially charge no interest for a promotional period, typically six to 18 months, an attractive feature for people worried about whether they can afford care. But if the debt is not paid in full when that time is up, costly rates — usually 25 to 30 percent — kick in, the review by *The Times* found. If payments are late, patients face

additional fees and, in most cases, their rates increase automatically. The higher rates are often retroactive, meaning that they are applied to patients' original balances, rather than to the amount they still owe....For patients, the financial consequences can be dire."²⁴⁰

- “A review by The New York Times of dozens of customer contracts for medical cards and lines of credit, as well as of hundreds of court filings in connection with civil lawsuits brought by state authorities and others, shows how perilous such financial arrangements can be for patients – and how advantageous they can be for health care providers.”²⁴¹
- “Doctors, dentists and others have a financial incentive to recommend the financing because it encourages patients to opt for procedures and products that they might otherwise forgo because they are not covered by insurance. It also ensures that providers are paid upfront – a fact that financial services companies promote in marketing material to providers.”²⁴²
- “[A]ttorneys general in a several states have filed lawsuits claiming that other dentists and professionals have misled patients about the financial terms of the cards, employed high-pressure sales tactics, overcharged for treatments and billed for unauthorized work.”²⁴³

“A.G. Schneiderman Issues Consumer Alert On Potential Dangers Of Medical Credit Cards,” Office of New York State Attorney General Eric Schneiderman, 2013.

In November, Schneiderman warned that increasing numbers of health care professionals are urging patients to use medical credit cards to pay for treatments not covered by their insurance plans because medical providers reap the benefits. As the N.Y. Attorney General explained, “Doctors, dentists and other providers have a financial incentive to recommend the financing because it encourages patients to opt for procedures and products they may not need. It also ensures that providers are fully paid upfront even for an ongoing course of treatment – a fact that financial services companies promote in marketing material to providers.”²⁴⁴

Medicare: Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions, U.S. Government Accountability Office, 2012.

- “From 2004 through 2010, the number of self-referred and non-self-referred advanced imaging services – magnetic resonance imaging (MRI) and computed tomography (CT) services – both increased, with the larger increase among self-referred services. For example, the number of self-referred MRI services increased over this period by more than 80 percent, compared with an increase of 12 percent for non-self-referred MRI services. Likewise, the growth rate of expenditures for self-referred MRI and CT services was also higher than for non-self-referred MRI and CT services.”

- “GAO’s analysis showed that providers’ referrals of MRI and CT services substantially increased the year after they began to self-refer – that is, they purchased or leased imaging equipment, or joined a group practice that already self-referred. Providers that began self-referring in 2009 – referred to as switchers – increased MRI and CT referrals on average by about 67 percent in 2010 compared to 2008. In the case of MRIs, the average number of referrals switchers made increased from 25.1 in 2008 to 42.0 in 2010. In contrast, the average number of referrals made by providers who remained self-referrers or non-self-referrers declined during this period. This comparison suggests that the increase in the average number of referrals for switchers was not due to a general increase in the use of imaging services among all providers.”
- “GAO’s examination of all providers that referred an MRI or CT service in 2010 showed that self-referring providers referred about two times as many of these services as providers who did not self-refer. Differences persisted after accounting for practice size, specialty, geography, or patient characteristics. These two analyses suggest that financial incentives for self-referring providers were likely a major factor driving the increase in referrals.”
- “GAO estimates that in 2010, providers who self-referred likely made 400,000 more referrals for advanced imaging services than they would have if they were not self-referring. These additional referrals cost Medicare about \$109 million.”
- “To the extent that these additional referrals were unnecessary, they pose unacceptable risks for beneficiaries, particularly in the case of CT services, which involve the use of ionizing radiation that has been linked to an increased risk of developing cancer.”²⁴⁵

“Hospital Chain Inquiry Cited Unnecessary Cardiac Work,” *New York Times*, August 7, 2012.

- “[U]nnecessary – even dangerous – procedures were taking place at some HCA hospitals, driving up costs and increasing profits.”
- “HCA, the largest for-profit hospital chain in the United States with 163 facilities, had uncovered evidence as far back as 2002 and as recently as late 2010 showing that some cardiologists at several of its hospitals in Florida were unable to justify many of the procedures they were performing. ... In some cases, the doctors made misleading statements in medical records that made it appear the procedures were necessary, according to internal reports.”
- “[T]he documents suggest that the problems at HCA went beyond a rogue doctor or two....”
- “Cardiology is a lucrative business for HCA, and the profits from testing and performing heart surgeries played a critical role in the company’s bottom line in recent years.”²⁴⁶

“For-profit hospitals performing more C-sections,” *California Watch*, 2010.

An investigative team recently looked at C-Section rates in California, which has had a \$250,000 cap on damages since 1975. It found that from 2005-2007.²⁴⁷

- “[W]omen are at least 17 percent more likely to have a cesarean section at a for-profit hospital than at one that operates as a non-profit. A surgical birth can bring in twice the revenue of a vaginal delivery.”
- “[S]ome hospitals appear to be performing more C-sections for non-medical reasons – including an individual doctor’s level of patience and the staffing schedules in maternity wards, according to interviews with health professionals.”
- “In California, hospitals can increase their revenues by 82 percent on average by performing a C-section instead of a vaginal birth....”²⁴⁸

“The Cost of Dying: End-of-Life Care,” *60 Minutes*, 2010.

- “Last year, Medicare paid \$55 billion just for doctor and hospital bills during the last two months of patients’ lives. That’s more than the budget for the Department of Homeland Security, or the Department of Education. And it has been estimated that 20 to 30 percent of these medical expenses may have had no meaningful impact.”
- “[T]here are other incentives that affect the cost and the care patients receive. Among them: the fact that most doctors get paid based on the number of patients that they see, and most hospitals get paid for the patients they admit... ‘So, the more M.R.I. machines you have, the more people are gonna get M.R.I. tests?’ [Steve] Kroft asked. ‘Absolutely,’ [Dr. Elliott Fisher, a researcher at the Dartmouth Institute for Health Policy] said.”²⁴⁹

“Doctors Reap Benefits By Doing Own Tests,” *Washington Post*, 2009.

The paper obtained Wellmark Blue Cross and Blue Shield documents, which showed that in 2005, doctors at a medical clinic on the Iowa-Illinois border were ordering eight or nine CT scans a month in August and September of 2005. But after those doctors bought their own CT scanner, within seven months, those numbers ballooned by 700 percent. The *Post* did a similar analysis of the Wellmark data for doctors in the region and found that after CT scanners were purchased, the number of scans they ordered was triple that of other area doctors who hadn’t purchased such equipment. The paper also cited consistent data from the GAO and MedPac. Jean M. Mitchell, a professor for public policy and a health economist at Georgetown University, suggested that getting rid of profit-driven medicine like this “could reduce the nation’s health care bill by as much as a quarter.”²⁵⁰

"The Cost Conundrum: What a Texas town can teach us about health care," *New Yorker*, 2009.

The following exchange took place with a group of doctors and author, Dr. Atul Gawande.²⁵¹

"It's malpractice," a family physician who had practiced here for thirty-three years said.

"McAllen is legal hell," the cardiologist agreed. Doctors order unnecessary tests just to protect themselves, he said. Everyone thought the lawyers here were worse than elsewhere.

That explanation puzzled me. Several years ago, Texas passed a tough malpractice law that capped pain-and-suffering awards at two hundred and fifty thousand dollars. Didn't lawsuits go down?

"Practically to zero," the cardiologist admitted.

"Come on," the general surgeon finally said. "We all know these arguments are bullshit. There is overutilization here, pure and simple." Doctors, he said, were racking up charges with extra tests, services, and procedures.

PART 3: PHYSICIAN SUPPLY AND ACCESS TO HEALTH CARE

❖ “TORT REFORM” DOES NOT INCREASE THE NUMBER OF PATIENT CARE PHYSICIANS

“Does Medical Malpractice Reform Increase Physician Supply? Evidence from the Third Reform Wave,” Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black et al., 2014.

The authors examined physician supply in nine states that enacted caps during the last “hard” insurance market (2002 to 2005)²⁵² and compared these data to other “control” states. They found “no evidence that cap adoption predicts an increase in total patient care physicians, in specialties that face high med mal risk (except plastic surgeons), or in rural physicians.”²⁵³ Specifically:

- “[W]e find no evidence that the adoption of damage caps increased physician supply in nine new-cap states, relative to twenty no-cap states.”²⁵⁴
- “Consistent with this analysis, we also find no association between med mal claim rates and physician supply in state and county fixed effects regressions over 1995-2011.”²⁵⁵
- “Physician supply does not seem elastic to med mal risk. Thus, the states that want to attract more physicians should look elsewhere.”²⁵⁶

“Does tort reform affect physician supply? Evidence from Texas,” University of Illinois Professor of Law and Medicine David A. Hyman et al., 2015.

The methodology of this study, which controls for every conceivable factor, is so accurate that a national “tort reform” proponent admitted changing his mind about the issue after examining this work.²⁵⁷

- A “core argument” behind the “tort reform” campaign was that “Texas was hemorrhaging physicians and limiting lawsuits would stop the bleeding. Consistent with this theme, the core pro-tort-reform lobbying organization was named ‘Texas Association for Patient Access’ (‘TAPA’).”²⁵⁸
- “[T]he assertion by tort reform proponents that Texas experienced an ‘amazing turnaround’ after suffering an ‘exodus of doctors from 2001 through 2003’ is doubly false. There was neither an exodus before reform nor a dramatic increase after reform.”²⁵⁹

- “Texas was not hemorrhaging physicians before tort reform was enacted in 2003.” In fact, “[t]he number of [direct patient care] DPC physicians steadily increased,” even while insurance rates were increasing during the nation’s last “hard” insurance market. Moreover, “the number of DPC physicians per capita rose steadily from 1993-2003.”²⁶⁰
- “[T]he rate of increase in Texas DPC physicians per capita was lower after reform.”²⁶¹
- “[T]ort reform did not solve Texas’ physician supply issues.”²⁶²
- **Specialists.** Two specialties (ob-gyn and orthopedic surgery) grew more quickly before tort reform than after. Only a third specialty (neurosurgery) grew more quickly after caps passed, keeping up with population. In other words, “there is no evidence of dramatic post-reform inflows”²⁶³ for ob-gyns, orthopedic surgeons or neurosurgeons.
- **Primary care physicians.** “[T]he absolute number of DPC physicians grew at roughly the same rate during the pre- and post-reform periods. If anything, the increase was slower, on average, during the eight post-reform years (2004-2011) than in the preceding eight years (1996-2003).”²⁶⁴
- **Rural areas.** “[T]here is no evidence that tort reform materially affected the supply of DPC physicians, primary care physicians, high-risk specialists, or physicians practicing in rural areas.”²⁶⁵

Data Cited By The Texas Medical Board Are Misleading And Wrong.

The Texas Medical Board (TMB) often cites statistics showing a post-2003 increase in “the number of applications to practice medicine it receives, the number of licenses it issues, and the number of doctors practicing in identified specialties by county.”²⁶⁶ These data are extremely problematic.

- “[S]imply adding up post-reform licenses”²⁶⁷ means little because of others factors influencing physician licenses in Texas during this time.
 - The authors note, “In a 2010 report, the Texas Department of State Health Services suggested that an increase in ‘direct patient care’ physicians in 2005 was ‘partially due to Hurricane Katrina.’”²⁶⁸
- TMB “data on applications and new licenses (which is what tort reform proponents have focused on) is severely flawed because it does not reflect physicians who leave Texas or retire. Without knowing both how many new doctors arrived and how many old doctors departed, one cannot tell whether the number of doctors in Texas rose, fell, or was unchanged.”²⁶⁹
- TMB “licensing data do not indicate how many physicians are engaged in patient care. Many licensed physicians are researchers, administrators, or otherwise occupied with non-clinical tasks,”²⁷⁰ *i.e.*, doctors who do not treat patients.

- The appropriate statistics are those used by the Texas Department of State Health Services, which are publicly available, reflecting active DPC physicians. It is these data on which the authors' of this study base their findings.²⁷¹

What Determines Physician Supply in Texas and Elsewhere.

“Physician supply appears to be primarily driven by factors other than liability risk, including population trends, location of the physician’s residency, job opportunities within the physician’s specialty, lifestyle choices, and demand for medical services, including the extent to which the population is insured.”²⁷²

Texas’s Data Collection Laws, Which Most States Don’t Have, Are Critical For This Kind Of Analysis.

The authors write, “We close by emphasizing the importance of publicly available, reliable, longitudinal data, collected on a time-consistent basis. It would not have been possible to perform this study (or the other studies we have done using Texas’ closed claims data) without this data. Texas should be commended for creating a closed claims database in 1988, and maintaining it over the intervening decades. Other states should emulate Texas.”²⁷³

❖ MANY STUDIES CONFIRM THAT “TORT REFORM” HAS HAD NO EFFECT ON PHYSICIAN SUPPLY NATIONALLY.

“The Empirical Effects of Tort Reform,” Cornell University Law School Professor Theodore Eisenberg, 2012.

“If increasing premiums drive exit decisions, then programs alleviating premiums should have effects. But Smits et al. (2009) surveyed all obstetrical care providers in Oregon in 2002 and 2006. Cost of malpractice premiums was the most frequently cited reason for stopping maternity care. An Oregon subsidy program for rural physicians pays 80 percent of the professional liability premium for an ob/gyn and 60 percent of the premium for a family or general practitioner. Receiving a malpractice subsidy was not associated with continuing maternity services by rural physicians. Subsidized physicians were as likely as nonsubsidized physicians to report plans to stop providing maternity care services. And physician concerns in Oregon should be interpreted in light of the NCSC finding, described above, that this was a period of substantial decline of Oregon medical malpractice lawsuit filings.”²⁷⁴

“Changes In Physician Supply And Scope Of Practice During A Malpractice Crisis: Evidence From Pennsylvania,” Harvard School of Public Health Professor Michelle Mello et al., 2007.

In April 2007, Mello and her colleagues published a study of physician supply in Pennsylvania in the peer-reviewed journal, *Health Affairs*. The authors “looked at the behavior of physicians in ‘high-risk’ specialties – practice areas such as obstetrics/gynecology and cardiology for which malpractice premiums tend to be relatively high – over the years from 1993 through 2002. They found that contrary to predictions based on the findings of earlier physician surveys, only a small percentage of these high-risk specialists reduced their scope of practice (for example, by eliminating high-risk procedures) in the crisis period, 1999-2002, when malpractice insurance premiums rose sharply.”²⁷⁵

“What’s more, the proportion of high-risk specialists who restricted their practices during the crisis period was not statistically different from the proportion who did so during 1993-1998, before premiums spiked. ‘It doesn’t appear that the restrictions we did observe after 1999 were a reaction to the change in the malpractice environment,’ said Mello, the C. Boyden Gray Professor of Health Policy and Law at the Harvard School of Public Health.”²⁷⁶

Dartmouth Medical School Professor of Pediatrics and Health Policy David Goodman, M.D., M.S., 2009.

Goodman is co-investigator of the highly respected Dartmouth Atlas, which analyzes and ranks health care spending and has been the basis of a lot of discussion about why certain areas of the country are so costly. In an email to the Center for Justice & Democracy, he said: “We haven’t explicitly analyzed this, but I agree with the impression that physician supply in general bears no relationship to state tort reform, or lack thereof.”²⁷⁷

“The Effect of Malpractice Liability on the Delivery of Health Care,” National Bureau of Economic Research, 2004.

In August 2004, National Bureau of Economic Research researchers found: “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 arguments that state tort reforms will avert local physician shortages or lead to greater efficiencies in care are not supported by our findings.”²⁷⁸

“Region Gains Doctors Despite Malpractice Bills,” Cincinnati Enquirer, 2004.

The paper reviewed public records in Ohio in the midst of that state’s medical malpractice insurance crisis. The investigation found “more doctors in the state today than there were three years ago ... [T]he data just doesn’t translate into doctors leaving the state,” says Larry Savage, president and chief executive of Humana Health Plan of Ohio.”²⁷⁹

Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care, U.S. General Accounting Office, 2003.

On August 29, 2003, the U.S. General Accounting Office (GAO) released a study²⁸⁰ ostensibly to find support for American Medical Association (AMA) assertions that a widespread health care access “crisis” existed in this country caused by doctors’ medical malpractice insurance problems. The GAO found that the AMA and doctors groups had based their claims on information GAO determined to be “inaccurate”²⁸¹ and “not substantiated,”²⁸² and that to the extent there are a few access problems, many other explanations can be established “unrelated to malpractice,”²⁸³ that problems “did not widely affect access to health care,”²⁸⁴ and/or “involved relatively few physicians.”²⁸⁵ The health care access problems that GAO could confirm were isolated and the result of numerous factors having nothing at all to do with the legal system. Specifically, GAO found that these pockets of problems “were limited to scattered, often rural, locations and in most cases providers identified long-standing factors in addition to malpractice pressures that affected the availability of services.”²⁸⁶

Earlier Studies.

Past studies have also shown no correlation between where physicians decide to practice and state liability laws. One study found that, “despite anecdotal reports that favorable state tort environments with strict ... tort and insurance reforms attract and retain physicians, no evidence suggests that states with strong ... reforms have done so.”²⁸⁷ A 1995 study of the impact of Indiana’s medical malpractice “tort reforms,” which were enacted with the promise that the number of physicians would increase, found that “data indicate that Indiana’s population continues to have considerably lower per capita access to physicians than the national average.”²⁸⁸

❖ **LIFESTYLE, FAMILY AND AGE CONSIDERATIONS ARE THE MOST IMPORTANT FACTOR FOR DETERMINING NOT ONLY A DOCTOR'S CHOICE OF LOCATION, BUT ALSO HIS OR HER CHOICE OF SPECIALTY.**

Center for Health Workforce Studies, School of Public Health, University at Albany, State University of New York, 2012.

When respondents - newly trained physicians - who were planning to practice outside of New York were asked their main reason for leaving the state, the most common reasons given were proximity to family (29%), better jobs in desired locations outside New York (12%), and better jobs outside New York that meet visa requirements (11%). The category "Cost of Malpractice Insurance" was practically dead last on this list. Even the general category "Other" outranked "Cost of Malpractice Insurance." New York's liability laws or legal environment were not even listed.²⁸⁹

"Young Doctors and Wish Lists: No Weekend Calls, No Beepers," *New York Times*, 2004.

"Today's medical residents, half of them women, are choosing specialties with what experts call a 'controllable lifestyle.' ... What young doctors say they want is that 'when they finish their shift, they don't carry a beeper; they're done,' said Dr. Gregory W. Rutecki, chairman of medical education at Evanston Northwestern Healthcare, a community hospital affiliated with the Feinberg School of Medicine at Northwestern University...

"Lifestyle considerations accounted for 55 percent of a doctor's choice of specialty in 2002, according to a paper in the *Journal of the American Medical Association* in September by Dr. [Gregory W.] Rutecki and two co-authors. That factor far outweighs income, which accounted for only 9 percent of the weight prospective residents gave in selecting a specialty."²⁹⁰ For example, compared to dermatology, which is becoming a more competitive specialty, "The surgery lifestyle is so much worse," said Dr. [Jennifer C.] Boldrick, who rejected a career in plastic surgery. 'I want to have a family. And when you work 80 or 90 hours a week, you can't even take care of yourself.'"²⁹¹

NYPIRG et al., *The Doctor Is In: New York's Increasing Number of Doctors*, 2004.

A University of California-San Francisco study of New York doctors found that the main reason doctors cease providing obstetrics care is advancing age. The UCSF study, of New York State physicians during the mid-1980s insurance crisis, found no association between malpractice premiums and doctors' decisions to quit. The report did find that the decrease in doctors practicing obstetrics was associated with the *length of time* since receiving a medical license in New York. This relationship "very likely represents the phenomenon of physician retiring from practice or curtailing obstetrics as they age."²⁹²

PART 4: MEDICAL MALPRACTICE INSURANCE

❖ MEDICAL MALPRACTICE INSURERS HAVE BEEN INCREDIBLY PROFITABLE IN RECENT YEARS.

“U.S. Medical Professional Liability Segment Produces Ninth Straight Year of Underwriting Profit,” *A.M. Best Special Report*, 2015.

The companies that specialize in medical professional liability (MPL) insurance achieved an overall underwriting profit for a ninth consecutive year in 2014... [The A.M. Best report] also finds that 2014 represented another year since 2003 of positive net income and the 11th year out of the last 12 of positive surplus growth (the outlier being 2008 due to the financial market collapse).²⁹³

“Malpractice Insurance Business is Booming in Wisconsin and Nation,” *Milwaukee Journal Sentinel*, June 28, 2014.

“Payments made to victims of medical malpractice are down, lawsuits filed against doctors and hospitals continue to plummet, and the industry in 2013 posted an underwriting profit for the eighth straight year, according to a May report by A.M. Best Co, an insurance company rating service. Some of the profits are even being passed on to doctors and hospitals through cuts in premium rates or dividends, the report noted.

“‘This is a boom time for physicians,’ said Michael Matray, editor of the *Medical Liability Monitor*, a Chicago trade magazine that follows the medical malpractice insurance industry. ‘And the industry is making money.’

“... ProAssurance Corp., the fourth-largest medical malpractice insurer in the country, recorded a 103% profit margin on its premiums nationwide in 2010, records filed with insurance regulators show. The company, which is based in Alabama, has continued to post extraordinary profits on its national medical malpractice business, with a 64.7% profit margin on its premiums last year, following margins of 86.4% in 2012 and 91% in 2011.

“‘The medical liability environment has been better than expected by anyone,’ said Howard Friedman, president of the ProAssurance’s health care professional liability group...As a group, the insurers posted an after-tax profit of \$1.5 billion last year, down from \$1.7 billion in 2012, A.M. Best reported. ‘The last four, five, six years have been uncharacteristically good,’ said Brian Atchinson, president and chief executive of PIAA, a national trade group for medical malpractice insurers.”²⁹⁴

“Annual Rate Survey Issue,” Medical Liability Monitor, 2013.

- “Since 2006, the U.S. [Medical Professional Liability] insurance sector has seen direct written premium fall by roughly 20 percent, suggesting a soft market. At the same time that this traditional soft market indicator has been in free-fall, however, the industry’s premium revenue has continued to outpace its claims expenses, with annual combined ratios for the sector coming in at well below 100 percent every year since 2006.”²⁹⁵
- “The combined ratio is a common insurance industry financial metric that compared the total cost of claims plus the money spent defending claims to the amount of premiums collected in a given year. Any number lower than 100 percent indicates underwriting profit (that is, profit before investment returns); anything over 100 percent represents an underwriting loss.”²⁹⁶
- “The sector’s combined ratio dropped below 100 percent in 2006 and has remained below that threshold each year since – an astonishing seven consecutive years of underwriting profit. All indications suggest that 2013 will continue this remarkable streak.”²⁹⁷
- “To put this record into historical perspective, consider that for the 28 years between 1978 and 2005, the sector enjoyed a combined ratio under 100 percent only twice, once in 1989 and once again in 1994.”²⁹⁸
- “To put this sector’s recent financial results into a current perspective, all other property and casualty lines of insurance had combined ratios of 100 percent, or well above, in 2012. Only MPL managed an underwriting profit last year.”²⁹⁹

Report on Profitability By Line By State in 2012, National Association of Insurance Commissioners, 2013.

The medical professional liability line of insurance has twice the return on net worth (11.3) as the overall average for the entire property/casualty industry (5.8).³⁰⁰

True Risk: Medical Liability, Malpractice Insurance And Health Care, Americans for Insurance Reform, 2009.

- In the report *True Risk*, Americans for Insurance Reform (AIR) found that no matter how profits were measured, medical malpractice insurers were doing incredibly well, especially when compared to every other sector in the economy.³⁰¹ Medical malpractice insurers admitted that they had “a very good” 2008.³⁰² This came “after posting record profits in 2007.”³⁰³ A.M. Best predicted that their “operating profits will continue through 2009.”³⁰⁴ And a quick look at the most recent data shows this to be true.
- The medical malpractice insurance industry had an overall return on net worth of 15.6%, *well over* the 12.5% overall profit for the entire property/casualty industry.³⁰⁵ According

to the National Association of Insurance Commissioners most recent data, overall return on net worth for the medical malpractice insurers for 2009 remains high at 15.3%.

- “Profitability can also be measured by the loss ratio, which compares the premiums that insurers take in and the money expected to be paid in claims. The lower the loss ratio, the less the insurer expects to pay for claims and the more profitable the insurer likely is (assuming all other things are equal.)”³⁰⁶ According to A.M. Best, “the loss ratio for medical malpractice insurers has been declining for at least five years.”³⁰⁷ In 2008, it was remarkably low, at 61.1%. Put another way, medical malpractice insurers believe they will pay out in claims only 61.1 cents for each premium dollar they take in. The rest goes towards overhead and profit.”³⁰⁸ This profit is in addition to the profit the insurer makes by investing premiums.
- “Another way to illustrate how well insurers have been doing in recent years is by examining “reserves” – the money set aside for future claims. Reserves are often manipulated by insurers for reasons having little to do with actual claims. Indeed, according to A.M. Best, reserves were “redundant” (*i.e.* excessive) during the last hard market – 2002 to 2004.”³⁰⁹ In those years, insurers told lawmakers that they needed dramatically to raise rates for doctors in order to pay future claims. It wasn’t true. As reserves went up, so did rates.”^{310 311}
- Reserves are now dropping at a substantial rate, with a whopping 13.6% drop in the last two years examined by AIR.³¹²

❖ MEDICAL MALPRACTICE PREMIUMS HAVE BEEN DROPPING SINCE 2006; PREMIUMS ARE A SCAPEGOAT FOR OTHER PHYSICIAN PROBLEMS.

“State of the Medical Professional Malpractice Liability Insurance Market,” A.M. Best Webinar, 2015.

- All panelists agreed that med mal rates are still extremely stable, and there is no sign the soft market [i.e. low rates] is ending anytime soon. As Healthcare Services Group President and CEO Joseph Moody put it, we have “quite a ways to go before the soft market ends. Don’t see it ending in the near future.”³¹³
- One new reason premiums are down is because of a shift in physicians moving out of private practice, but also, there is strong competitive pricing (*i.e.*, an extended soft market period). PIAA called this “an historic cycle.” Go back 50 years of med mal liability coverage and there’s never been such a “sustained period of long-term results.”³¹⁴

Medical Malpractice Payments Remained at Historic Low in 2013 Despite Slight Uptick, Public Citizen, 2014.

“Medical liability rates vary by region and provider and are reported anecdotally. But the trend is downward. For instance, rates charged by the Doctors Company, a major provider of liability insurance, fell 35 percent between 2005 and 2012. In 2013, the Doctors Company decreased rates from 2.8 percent to 45.7 in Oregon, Illinois, Idaho, Mississippi and Washington, reported *SNL Insurance Daily*.

“Medical Protective Co., a Berkshire Hathaway-owned provider of medical liability insurance, filed plans with regulators to decrease rates from 3.2 percent to 30.7 percent in Indiana, Kansas and Massachusetts, *SNL Insurance Daily* reported in 2014.

“‘The medical space, no pun intended, is somewhat of a bloodbath, quite frankly, with rates continuing to fall off,’ W. Robert Berkley Jr. president of property and casualty firm W. R. Berkley Corp., said during a 2013 earnings call.”

“...[T]otal medical liability insurance costs, which are the chief subject of concern among those pushing for caps of court awards, are falling nationally. Combined liability premiums paid by physicians and medical institutions fell from \$10 billion in 2012 to \$9.8 billion in 2013, according to data provided to Public Citizen by A.M. Best. Cumulative payments for liability insurance premiums were 16.4 percent lower in 2013 than in 2005.”³¹⁵

“Why the Medical Malpractice Crisis Persists Even When Malpractice Insurance Premiums Fall,” Marc A. Rodwin, Suffolk University Law School; Harvard University - Edmond J. Safra Center for Ethics, Justin Silverman, 2014.

- “Concerns that medical malpractice premiums continue to grow unabated has led to numerous proposals to change liability rules and reform tort laws. Not only would proposed legislation make lawsuits more difficult for plaintiffs, but the bills do not address the real source of the problems they intend to solve. Premiums are not rising as claimed and even if they were, other factors are contributing to the plight of physicians. But in fact, the claim that malpractice premiums are an unbearable burden for most physicians is myth, not fact.³¹⁶
- “Those who in recent years claimed that there is an ongoing crisis base that claim on anecdotes, unsupported assertions or flawed data.
- “When physicians are financially squeezed they might perceive malpractice premiums to be the culprit. In fact, when a physician’s income does not grow, fails to keep up with inflation or declines altogether, the problem is not usually due to malpractice premiums. The problem is more typically due to health insurers that clamp down on the size of physician fees and deny payment for services that they deem unnecessary. Malpractice premiums can be a convenient scapegoat for frustrated physicians.”

“Malpractice Premiums Drop for 6th Straight Year,” Medscape, October 10, 2013.

- “Collective rates for obstetrician-gynecologists, internists, and general surgeons fell on average for the sixth straight year in 2013, according to an annual premium survey released this week by *Medical Liability Monitor (MLM)*.³¹⁷
- “The 1.7% drop in premium rates this year for the combined specialties of obstetrics-gynecology, general surgery, and internal medicine...applies more or less to each individual specialty as well.”³¹⁸
- According to Chad Karls, Milliman principal and consulting actuary who summarized the premium trends for *MLM*, falling premiums “reflect a roughly 50% drop in malpractice claims per physician since the liability crisis in the early 2000s that the AMA references.”³¹⁹
- “For proponents of tort reform, ‘the wind has been taken out of their sails a little bit,’” said Karls. “‘Premium costs are lower than what they were a decade ago.’”³²⁰

“First Look: 2012 First Quarter Results for Medical Professional Liability Specialty Writers,” *Medical Liability Monitor*, July 2012.

“[P]remiums are still declining” and “insurers continue to benefit from the persistent, favorable reserve releases...first-quarter-2012 direct written premium is down another 0.9 percent compared to the first quarter 2011. ... Direct written premium for this composite is down almost 20 percent since its peak in 2006.”³²¹ [Note that “favorable reserve releases” derive from the previous “hard market” when insurers bloated reserves to justify rate hikes.]

True Risk: Medical Liability, Malpractice Insurance And Health Care, Americans for Insurance Reform, 2009.

- “According to A.M. Best, after reaching a high of 14.2% in 2003 during the last hard market, medical malpractice premium growth has been dropping, decreasing by 6.6% nationally in 2007, and an additional 5.3% in 2008.”³²²
- “The insurance pure premium³²³ or loss costs,³²⁴ is particularly important to examine. This is the one component of an insurance rate that should be affected by verdicts, settlements, payouts or so-called “tort reform.” It is the largest part of the premium dollar for most lines of insurance.”³²⁵ The Insurance Services Office (ISO)³²⁶ “shows the same cyclical pattern with the biggest increases during the hard market of 2002-2005, and dropping steadily since then with 2008 seeing an astonishing 11% decrease. This confirms that we are experiencing a very soft market.”³²⁷ Moreover, “this decrease might have been even greater had 17 states not limited the decrease to 20%, likely because ISO wanted to control this drop. Most likely, this result was due to the recognition that, with profits as high as they were, medical malpractice insurance for doctors was greatly overpriced in prior years.”³²⁸

❖ **PREMIUMS HAVE DROPPED IRRESPECTIVE OF WHETHER “TORT REFORMS” HAVE BEEN ENACTED IN ANY PARTICULAR STATE.**

True Risk: Medical Liability, Malpractice Insurance And Health Care, Americans for Insurance Reform, 2009.

- “States with little or no restrictions on patients’ legal rights have experienced the same level of liability insurance rate changes as those states that enacted severe restrictions on patients’ rights.”³²⁹
- “Compare, Missouri and Iowa, two neighboring Midwest states. Missouri had a cap since the mid-1980s, as well as other ‘tort reform’ in medical malpractice cases. (This cap was struck down as unconstitutional in July 2012 - 26 years after its enactment.³³⁰) Iowa never had a cap. In the last five years examined, Missouri’s pure premium increased 1%. Iowa’s dropped 6%. Among states that had pure premium increases of more than 5% in the last five years were states with significant medical malpractice limits like FL, NV, and UT, and states with fewer restrictions like NH, VT and WY.”³³¹

❖ “CAPS” DO NOT LOWER INSURANCE PREMIUMS FOR DOCTORS.

Comparing Maryland and Missouri: Two states that enacted severe caps on damages in the mid-1980s, only to be hit with huge rate hikes during the last hard market.

- **Maryland.** In the mid-2000s, Maryland was called an American Medical Association (AMA) “problem state”³³² and a “crisis state” according to the American College of Obstetricians and Gynecologists because insurance rates had suddenly jumped.³³³ Yet Maryland had had a cap on non-economic damages since 1986, originally \$350,000 but later increased somewhat.³³⁴ Despite the cap, the state experienced premiums that “rose by more than 70 percent in the last two years.”³³⁵ This caused lawmakers to push for, once again, even more restrictions on patients’ rights in a special session called by the Governor in 2004 ostensibly “to combat the high cost of malpractice insurance.”³³⁶
- **Missouri.** It was also identified by the AMA as a so-called “crisis state,”³³⁷ yet had had a cap on non-economic damages since 1986. (This cap was struck down as unconstitutional in July 2012 – 26 years after its enactment.³³⁸) The cap started at \$350,000 and was adjusted annually for inflation, reaching \$557,000 in 2003.³³⁹ “New medical malpractice claims dropped 14 percent in 2003 to what the [Missouri Department of Insurance] said was a record low, and total payouts to medical malpractice plaintiffs fell to \$93.5 million in 2003, a drop of about 21 percent from the previous year.”³⁴⁰ And “[t]he National Practitioner Data Bank, a federally mandated database of malpractice claims against physicians, found that the number of paid claims in Missouri fell by about 30 percent since 1991. The insurance department’s database found that paid claims against physicians fell 42.3 percent during the same time period.”³⁴¹ *Yet doctors’ malpractice insurance premiums rose by 121 percent between 2000 and 2003.*³⁴²

Other States.

- **Florida.** “When Gov. Jeb Bush and House Speaker Johnnie Byrd pushed through a sweeping medical malpractice overhaul bill . . . the two Republican leaders vowed in a joint statement that the bill would ‘reduce ever-increasing insurance premiums for Florida’s physicians . . . and increase physicians’ access to affordable insurance coverage.’”³⁴³ But, insurers soon followed up with requests to increase premiums by as much as 45 percent.
- **Mississippi.** Four months after “caps” passed, investigative news articles reported that surgeons still could not find affordable insurance and that many Mississippi doctors were still limiting their practice or walking off the job in protest.³⁴⁴
- **Nevada.** Within weeks of enactment of “caps” in the summer of 2002, two major insurance companies proclaimed that they would not reduce insurance rates for at least another year to two, if ever. The Doctors Company, a nationwide medical malpractice insurer, then filed for a 16.9 percent rate increase. Two other companies filed for 25 percent and 93 percent rate increases.³⁴⁵

- **Ohio.** Almost immediately after “tort reform” passed, all five major medical malpractice insurance companies in Ohio announced they would not reduce their rates. One insurance executive predicted his company would seek a 20 percent rate increase.³⁴⁶
- **Oklahoma.** After “caps” passed in 2003, the third-largest medical malpractice insurer in the state raised its premiums 20 percent, followed by an outrageous 105 percent rate hike in 2004.³⁴⁷ The largest insurance company, which is owned by the state medical association, requested an astounding 83 percent rate hike just after “tort reform” passed (which was approved on the condition it be phased in over three years).³⁴⁸
- **Texas.** During the 2003 campaign for Prop. 12 – the “tort reform” referendum that passed – ads promised rate cuts if caps were passed. Right after the referendum passed, major insurers requested rate hikes as high as 35 percent for doctors and 65 percent for hospitals.³⁴⁹ In April 2004, after one insurer’s rate hike request was denied, it announced it was using a legal loophole to avoid state regulation and increase premiums 10 percent without approval.³⁵⁰ In a 2004 filing to the Texas Department of Insurance, GE Medical Protective revealed that the state’s non-economic damage cap would be responsible for no more than a 1 percent drop in losses.³⁵¹

❖ INDUSTRY INSIDERS HAVE REPEATEDLY SAID THAT CAPPING DAMAGES WILL NOT LOWER INSURANCE RATES.

- **American Insurance Association:** “[T]he insurance industry never promised that tort reform would achieve specific premium savings.”³⁵²
- **Sherman Joyce, President, American Tort Reform Association:** “We wouldn’t tell you or anyone that the reason to pass tort reform would be to reduce insurance rates.”³⁵³
- **Victor Schwartz, General Counsel, American Tort Reform Association:** “[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and ‘I’ve never said that in 30 years.’”³⁵⁴
- **State Farm Insurance Company (Kansas):** “[W]e believe the effect of tort reform on our book of business would be small. ... [T]he loss savings resulting from the non-economic cap will not exceed 1% of our total indemnity losses.....”³⁵⁵
- **Aetna Casualty and Surety Co. (Florida):** After Florida enacted what Aetna Casualty and Surety Co. characterized as “full-fledged tort reform,” including a \$450,000 cap on non-economic damages, Aetna did a study of cases it had recently closed and concluded that Florida’s tort reforms would not effect Aetna’s rates. Aetna explained that “the review of the actual data submitted on these cases indicated no reduction of cost.”³⁵⁶
- **Allstate Insurance Company (Washington State):** In asking for a 22% rate increase following passage of tort reform in Washington State, including a cap on all damage awards, the company said, “[O]ur proposed rate would not be measurably affected by the tort reform legislation.”³⁵⁷
- **Great American West Insurance Company (Washington State):** After the 1986 Washington tort reforms, the Great American West Insurance Company said that on the basis of its own study, “it does not appear that the ‘tort reform’ law will serve to decrease our losses, but instead it potentially could increase our liability. We elect at this point, however, not to make an upward adjustment in the indications to reflect the impact of the ‘tort reform’ law.”³⁵⁸
- **Vanderbilt University:** A regression analysis conducted by Vanderbilt University Economics Professor Frank Sloan found that caps on economic damages enacted after the mid 1970’s insurance crisis had no effect on insurance premiums.³⁵⁹

❖ STRONG INSURANCE REGULATORY LAWS ARE THE ONLY WAY TO CONTROL INSURANCE RATES FOR DOCTORS AND HOSPITALS.

Comparing California and Illinois: Two states that enacted both severe caps on damages and strong insurance regulation.

CALIFORNIA

Cap. In 1975, California enacted a severe \$250,000 cap on non-economic damages, the first in the nation. This cap has greatly reduced the number of genuine malpractice cases brought in California.

- Despite the reduction of legitimate cases, between 1975 and 1988, doctors' premiums in California increased by 450 percent, rising faster than the national average.³⁶⁰
- As a result of the cap, California's medical malpractice insurance industry became so bloated that "as little as 2 or 3 percent of premiums are used to pay claims" and "the state's biggest medical malpractice insurer, Napa-based The Doctors Company, spent only 10 percent of the \$179 million collected in premiums on claims in 2009." Insurance Commissioner Dave Jones said that "insurers should reduce rates paid by doctors, surgeons, clinics and health providers while his staff scrutinizes the numbers."³⁶¹

Insurance regulation: In 1988, California voters passed a stringent insurance regulatory law, Proposition 103 (Prop. 103), which ordered a 20% rate rollback, forced companies to open their books and get approval for any rate change before it takes effect, and allowed the public to intervene and challenge excessive rate increases.

- In the twelve years after Prop. 103 (1988-2000), malpractice premiums dropped 8 percent in California, while nationally they were up 25 percent.³⁶²
- During the period when every other state was experiencing skyrocketing medical malpractice rate hikes in the mid-2000s, California's regulatory law led to public hearings on rate requests by medical malpractice insurers in California, which resulted in rate hikes being lowered three times in two years,³⁶³ saving doctors \$66 million.
- Prop. 103 has allowed the state Insurance Commissioner to take action and lower excessive insurance rates for doctors. According to an October 2012 news release issued by the California Department of Insurance,³⁶⁴
 - "Insurance Commissioner Dave Jones today announced the second medical malpractice rate reduction this year for NORCAL Mutual Insurance Company's physician and surgeon program. The company's 6.9 percent reduction saves

primarily Southern California doctors approximately \$8.5 million annually. This company initiated rate reduction follows a Department ordered 7.1 percent decrease in March for an overall savings of \$18 million this year alone for physicians and surgeons insured by NORCAL Mutual.”

- “Last year Commissioner Jones ordered the top six medical malpractice insurance companies in California to submit rate filings to the Department of Insurance to justify their current rates. After a thorough review of those filings, Commissioner Jones called for rate reductions. As a result of the Commissioner’s rejection of excessive rates, all six companies lowered their medical malpractice rates,” amounting to “a total savings to medical providers of \$52 million....”
- “‘I’m pleased the medical malpractice rates are continuing to be decreased under the Department’s rate review process and authority,’ said Commissioner Jones. ‘These medical malpractice rate reductions show the important role that Proposition 103, which authorizes the insurance Commissioner to reject excessive rate hikes for property and casualty insurance, including medical malpractice insurance, has played in curbing medical malpractice rates since it was passed in 1988.’”

ILLINOIS

In 2005, Illinois enacted a non-economic damages cap on compensation for injured patients (\$500,000 for doctors and \$1,000,000 for hospitals) and a very strong insurance regulatory law. In February 2010, the Illinois Supreme Court struck down this cap as unconstitutional.³⁶⁵ Because of a non-severability clause, the insurance regulatory law was struck down, as well. In the five years these laws were in place, the following occurred:

Cap: The cap never really affected settlements or insurance rates in Illinois during the five years it existed. This was acknowledged in a May 2010 webinar sponsored by A.M. Best, where a Chicago-based insurance attorney said:

“It may be headlines in other places but here in Cook County [Illinois] I think that the Supreme Court’s decision in *Lebron* was fully anticipated and discounted. None of the settlements that I’ve been involved in for the last couple of years paid the slightest attention to the caps anymore. There was almost a universal acceptance that it would be overturned by the Supreme Court. In fact it was overturned in Cook County two years ago. *Lebron* was a Cook County case going up, so the caps haven’t been law here for quite some time.”³⁶⁶

Insurance Regulation: The strong insurance regulatory reforms *did* take effect and had an impact.

In October 2006, the Illinois Division of Insurance announced that an Illinois malpractice insurer, Berkshire Hathaway’s MedPro, would be expanding its coverage and cutting

premiums for doctors by more than 30 percent. According to state officials and the company itself, this was made possible because of new insurance regulatory law enacted by Illinois lawmakers in 2005, and expressly not the cap on compensation for patients.³⁶⁷ The new law required malpractice insurers to disclose data on how to set their rates. This, according to Michael McRaith, director of the state's Division of Insurance, allowed MedPro to "set rates that are more competitive than they could have set before."³⁶⁸

In February 2010, the Illinois Division of Insurance released data showing that insurance regulation had greatly improved the medical malpractice insurance environment with expanded coverage and lower premiums for doctors.³⁶⁹ Specifically, the insurance division said:

"The 2005 Reform Laws imposed changes to the Illinois Insurance Code that improved insurer reporting and transparency requirements and enhanced the Department's rate oversight authority. Since 2005, the Department has observed improvements in the medical malpractice insurance market. In particular, the Department observed:

- **A decrease in medical malpractice premiums.** Gross premium paid to medical malpractice insurers has declined from \$606,355,892 in 2005 to \$541,278,548 in 2008;
- **An increase in competition among companies offering medical malpractice insurance.** In 2008, 19 companies offering coverage to physicians/surgeons each collected more than \$500,000 in premiums, an increase from 14 such companies in 2005; and
- **The entry into Illinois of new companies offering medical malpractice insurance.** In 2008, five companies collected more than \$22,000,000 in combined physicians/surgeons premiums – and at least \$1,000,000 each in premiums – that did not offer medical malpractice insurance in 2005."³⁷⁰

PART 5: PATIENT SAFETY

❖ MEDICAL ERRORS OCCUR IN ALARMING NUMBERS AND ARE EXTREMELY COSTLY.

It has been over a decade since the Institute of Medicine's (IOM) seminal study "To Err is Human"³⁷¹ was published, which found that between 44,000 and 98,000 patients are killed (and many more injured) in hospitals each year due to medical errors, costing the nation between \$17 billion and \$29 billion each year. Recent studies confirm that patient safety has not improved and has gotten worse.

Improving Diagnosis in Health Care, Institute of Medicine, 2015

"The delivery of health care has proceeded for decades with a blind spot: Diagnostic errors – inaccurate or delayed diagnoses – persist throughout all settings of care and continue to harm an unacceptable number of patients. For example:

- A conservative estimate found that 5 percent of U.S. adults who seek outpatient care each year experience a diagnostic error.
- Postmortem examination research spanning decades has shown that diagnostic errors contribute to approximately 10 percent of patient deaths.
- Medical record reviews suggest that diagnostic errors account for 6 to 17 percent of hospital adverse events.
- Diagnostic errors are the leading type of paid medical malpractice claims, are almost twice as likely to have resulted in the patient's death compared to other claims, and represent the highest proportion of total payments.

In reviewing the evidence, the committee concluded that most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences."³⁷²

"Evaluation of Perioperative Medication Errors and Adverse Drug Events," Massachusetts General Hospital Anesthesiologist and Harvard Medical School Assistant Professor Karen C. Nanji, M.D., M.P.H. et al., 2015

In a first-of-its-kind study measuring the incidence of medication errors and adverse drug events during the period immediately before, during and right after a surgical procedure, researchers found the following³⁷³:

- "[S]ome sort of mistake or adverse event occurred in every second operation and in 5 percent of observed drug administrations."

- “Of the almost 3,675 medication administrations in the observed operations, 193 events, involving 153 medication errors and 91 adverse drug events, were recorded either by direct observation or by chart review. Almost 80 percent of those events were determined to have been preventable.”
- “Of all the observed adverse drug events and medication errors that could have resulted in patient harm – four of which were intercepted by operating room staff before affecting the patient – 30 percent were considered significant, 69 percent serious, and less than 2 percent life-threatening; none were fatal.”
- “The most frequently observed errors were mistakes in labeling, incorrect dosage, neglecting to treat a problem indicated by the patient’s vital signs, and documentation errors.”

“Preventing falls and fall-related injuries in health care facilities,” Joint Commission, 2015

- “Every year in the United States, hundreds of thousands of patients fall in hospitals, with 30-50 percent resulting in injury.”³⁷⁴
- “Injured patients require additional treatment and sometimes prolonged hospital stays. In one study, a fall with injury added 6.3 days to the hospital stay.”³⁷⁵
- “The average cost for a fall with injury is about \$14,000.”³⁷⁶

Hospital Safety Scores, Leapfrog Group, 2015

The Leapfrog Group found that of the 28 measures used to calculate the A, B, C, D or F grades, “on average, hospital performance improved on eight measures, but average performance declined on six measures.” In addition, “[d]espite the powerful stories of improving and high-performing hospitals, improvement across the board remains elusive. The Fall 2015 update shows a number of positive trends for certain hospital-acquired conditions and safety measures, but hospitals are performing worse on critical measures like foreign objects left in after surgery.”³⁷⁷

“New Medicare data available to increase transparency on hospital utilization,” U.S. Center for Medicare and Medicaid Services, 2015.

In 2013, the second-greatest hospital Medicare expense, “\$5.6 billion, went for 398,004 cases of septicemia, or blood poisoning, often a sign of poor in-patient care.”³⁷⁸

“Deadly Infections Drive Billions in Hospital Bills to Medicare,” *Bloomberg*, June 3, 2015.

- “Life-threatening complications from bacterial infections are on the rise among hospital patients, increasing at a double-digit rate as the population ages and costing U.S. health-care programs billions of dollars a year.”³⁷⁹
- “One form of the condition, severe sepsis with a major complication, was the second most frequently billed diagnosis submitted by hospitals to Medicare in 2013, with more than 398,000 cases,” amounting to “15 percent more than in 2012 and 24 percent higher than in 2011....”³⁸⁰
- “The three sepsis-related codes included in [the Centers for Medicare & Medicaid Services] data accounted for about \$7.2 billion of Medicare payments to hospitals, up 9.5 percent from the previous year.”³⁸¹

“Incidence of ‘never events’ among weekend admissions versus weekday admissions to US hospitals: national analysis,” University of Southern California Medical School Neurosurgery Clinical Instructor Frank J. Attenello, M.D., et al., 2015.

Researchers analyzed data from more than 350 million U.S. hospital admissions from 2002 to 2010 and found the following:

- “16.7 million of [inpatient hospital] stays, or about 5 percent, resulted in at least one avoidable hospital-acquired condition.”³⁸²
- “Falls were the most common complication, occurring in 14 million admissions and accounting for 85 percent of all hospital-acquired conditions. Pressure sores and catheter-associated urinary tract infections were also common.”³⁸³

“Risks Are High at Low-Volume Hospitals,” *U.S. News & World Report*, May 18, 2015.

After analyzing Medicare data, the magazine found that “as many as 11,000 deaths nationally might have been prevented from 2010 through 2012 over the three years analyzed if patients who went to the lowest-volume fifth of the hospitals had gone to the highest-volume fifth.”³⁸⁴ As *U.S. News & World Report* argued, large numbers of low-volume hospitals “continue to put patients at higher risk even after three decades of published research have demonstrated that patients are more likely to die or suffer complications when treated by doctors who only occasionally see similar patients rather than by experienced teams at hospitals with more patients and established protocols.”³⁸⁵

“Wrong-Site Surgery, Retained Surgical Items, and Surgical Fires,” RAND Corporation Behavioral Scientist and Pardee Graduate School Professor Susanne Hempel, Ph.D., et al., 2015.

According to a comprehensive data review published in *JAMA Surgery*, every year there are an estimated 500 surgeries on the wrong body part and 5,000 surgical items unintentionally left in patients' bodies, "which constitute too many events."³⁸⁶

Surgeon Scorecard, ProPublica, 2015

After looking at death and complication rates for surgeons performing one of eight Medicare-covered elective procedures – knee replacement, hip replacement, gallbladder removal (laparoscopic), lumbar spinal fusion (posterior column), lumbar spinal fusion (anterior column), prostate removal, prostate resection or cervical (neck) spinal fusion – ProPublica found that 3,405 Medicare patients died during a hospital stay for elective surgery between 2009 and 2013 and over 63,000 Medicare patients were readmitted with complications during the same period.³⁸⁷

"Adverse Events in Robotic Surgery: A Retrospective Study of 14 Years of FDA Data," University of Illinois at Urbana-Champaign Engineering Professor Ravishankar K. Iyer et al., 2015

After examining over 10,000 incident reports from the FDA spanning from 2000 to 2013, researchers found that robots used in minimally invasive surgery were involved in 144 patient deaths, 1,391 patient injuries and 8,061 device malfunctions. Among the errors reported – burnt or broken pieces of tools falling into the patient (14.7 percent), electrical sparking of instruments (10.5 percent) and robots making unintended movements (8.6 percent) – the last of which resulted in 52 injuries and two deaths. In addition, more errors were reported in complicated cardiothoracic and head and neck surgeries than during gynecology and urology procedures.³⁸⁸

"In Hospitals, Board Rooms Are as Important as Operating Rooms," New York Times Upshot Blog, February 16, 2015.

"Several studies show that hospital boards can improve quality and can make decisions associated with reduced mortality rates. But not all boards do so,"³⁸⁹ even though "boards, and other hospital management, can influence care in ways that individual physicians cannot."³⁹⁰

"In general, hospital boards do not view themselves as institutional champions of quality... Only half of boards view clinical quality as one of their top two concerns. In contrast, financial performance was a top priority for about three-quarters of hospital boards.... Troublingly, most hospitals boards can't accurately assess their institution's quality. There's a Lake Wobegon effect: More than half of hospitals with low quality thought they were actually above average."³⁹¹

Predicting patient survival of high-risk surgeries, Leapfrog Group and Castlight Health Inc., 2014.

“The chance of surviving any of four high-risk surgeries can vary by as much as 23 percent depending on what hospital patients use,” according to 2013 data from 1,500 hospitals.³⁹² Among the study’s key findings³⁹³:

- “Pancreatectomy: This surgery to remove all or part of the pancreas has the most significant variance in survival rate by hospital, at 19 percent.”
- “Esophagectomy: Usually performed to treat cancer, an esophagectomy removes all or part of the esophagus. The average survival rate is 90 percent with a variation by hospital of 88 to 98 percent.”
- “AAA repair: A surgery to treat an enlarged abdominal aorta, the major blood vessel that supplies blood to the body, has a 13 percent variation in predicted survival rates, which range from 85.7 to 98.9 percent. This variation has increased since 2013.”
- “AVR: This heart surgery treats problems with the heart’s aortic valve, and only 17 percent of hospitals fully met Leapfrog’s standard.”

“Incidence of adverse events in an integrated US healthcare system: a retrospective observational study of 82,784 surgical hospitalizations,” Ohio State University College of Public Health Biostatistics Associate Professor Bo Lu, Ph.D., et al., 2014.

“46% to 65% of adverse events in hospitals are related to surgery, especially complex procedures.”³⁹⁴

“Fiscal Year 2015 Results for the CMS Hospital-Acquired Condition Reduction Program and Hospital Value-Based Purchasing Program,” Centers for Medicare & Medicaid Services, 2014.

In December 2014, the federal government announced that it would cut payments to roughly 724 hospitals for having high rates of infections and other patient injuries.³⁹⁵ As explained by *Kaiser Health News*, “One out of every seven hospitals in the nation will have their Medicare payments lowered by 1 percent over the fiscal year that began Oct. 1 and continues through September 2015. The health law mandates the reductions for the quarter of hospitals that Medicare assessed as having the highest rates of ‘hospital-acquired conditions,’ or HACs. These conditions include infections from catheters, blood clots, bed sores and other complications that are considered avoidable.”³⁹⁶ The penalties are estimated to total \$373 million.³⁹⁷

“Multistate Point-Prevalence Survey of Health Care-Associated Infections,” Centers for Disease Control and Prevention, 2014.

- “On any given day, approximately one in 25 U.S. patients has at least one infection contracted during the course of their hospital care....”³⁹⁸
- In 2011, “about 721,800 infections occurred in 648,000 hospital patients.”³⁹⁹
- “About 75,000 patients with healthcare-associated infections died during their hospitalizations.”⁴⁰⁰
- “The most common healthcare-associated infections were pneumonia (22 percent), surgical site infections (22 percent), gastrointestinal infections (17 percent), urinary tract infections (13 percent), and bloodstream infections (10 percent).”⁴⁰¹

“Watch Out for Urinary Tract Infections in Hospitals,” *Consumer Reports*, 2014.

After looking at infection rates in ICUs from April 2012 through March 2013 in about 2,300 hospitals in all 50 states plus Washington, D.C., and Puerto Rico, researchers found that more than 300 hospitals had at least twice the national average number of catheter associated urinary tract infections (CAUTIs).⁴⁰² Why? “Researchers from Columbia University and the CDC suggest it may be in part because hospitals have not yet focused on CAUTIs to the same extent that they have other kinds of infections.”⁴⁰³ Moreover, “among hospitals that had instituted policies, only up to a quarter were following them.”⁴⁰⁴

“Retained Surgical Sponges: Findings from Incident Reports and a Cost-Benefit Analysis of Radiofrequency Technology,” University HealthSystem Consortium, 2014.

As reported by the *Washington Post*,

“While rare, ‘retained surgical items’ can cause quite a bit of harm, beyond pain and suffering: readmission, additional surgeries, abscesses, intestinal fistulas, obstructions, visceral perforations and even death.

“Studies estimate that this happens once in every 5,500 to 7,000 surgeries; there were 51.4 million in-patient procedures performed in 2010, according to the National Center for Health Statistics. The authors of a new study estimate that a typical hospital has two of these incidents each year.

“Not surprisingly, each mistake is costly. In 2007, the Centers for Medicare and Medicaid Services estimated the average price of removing one of these items at \$63,631 per hospital stay, and larger settlements in lawsuits can run from \$2 million to \$5 million.”⁴⁰⁵

“Safety advocates push to curb hospital surgical fires,” *Modern Healthcare*, July 14, 2014.

“Despite a slew of news accounts about patients being set on fire in operating rooms across the country, adoption of precautionary measures has been slow, often implemented only after a hospital experiences an accident. Advocates say it’s not clear how many hospitals have instituted the available protocols, and no national safety authority tracks the frequency of surgical fires, which are thought to injure patients in one of every three incidents.

“About 240 surgical fires occur every year, according to rough estimates by the ECRI Institute, a not-for-profit organization that conducts research on patient-safety issues. ...The steady incidence of surgical-room fires alarms safety experts and advocates. ‘They should never happen,’ said Lisa McGiffert, director of the Safe Patient Project at the Consumers Union.”⁴⁰⁶

“Impact of Attending Physician Workload on Patient Care: A Survey of Hospitalists,” Johns Hopkins Assistant Professor of Medicine Henry J. Michtalik, M.D., M.P.H., M.H.S., et al., 2013.

A survey of hospital attending doctors published in *JAMA Internal Medicine* found that overworked hospital doctors are jeopardizing patient safety. More specifically,

- “Forty percent of physicians reported that their typical inpatient census exceeded safe levels at least monthly; 36% of these reported a frequency greater than once per week.”⁴⁰⁷
- “When we compared the reported workload to the estimated safe workload of individual physicians, 40% of hospitalists reported exceeding their own safe numbers.”⁴⁰⁸
- “Regardless of any assistance, physicians reported that they could safely see 15 patients per shift if their effort was 100% clinical.”⁴⁰⁹
- “Hospitalists frequently reported that excess workload prevented them from fully discussing treatment options, caused delay in patient admissions and/or discharges, and worsened patient satisfaction....”⁴¹⁰
- “Over 20% reported that their average workload likely contributed to patient transfers, morbidity, or even mortality.”⁴¹¹
- “This study has significant policy implications. First, hospitals need to routinely evaluate workloads of attending physicians, create standards for safe levels of work, and develop mechanisms to maintain workloads at safe levels. Second, society needs to reduce health care costs but do so wisely. The main mechanism for reducing costs is to pay less for services, assuming that providers and institutions will increase productivity and efficiency. Hospital administrators largely respond to payment reduction by increasing

workload. However, excessively increasing the workload may lead to suboptimal care and less direct patient care time, which may paradoxically increase, rather than decrease, costs.”⁴¹²

“A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care,” Patient Safety America, 2013.

According to the report, published in the *Journal of Patient Safety*, “between 210,000 and 440,000 patients each year who go to the hospital for care suffer some type of preventable harm that contributes to their death, the study says. That would make medical errors the third-leading cause of death in America, behind heart disease, which is the first, and cancer, which is second.”⁴¹³ Leading patient safety researchers – including Dr. Lucian Leape, Dr. David Classen and Dr. Marty Makary, have endorsed this study.⁴¹⁴

“25-Year summary of US malpractice claims for diagnostic errors 1986-2010: an analysis from the National Practitioner Data Bank,” Johns Hopkins University School of Medicine Associate Professor of Neurology David E. Newman-Toker, M.D., Ph.D. et al., 2013.

Johns Hopkins researchers reviewed National Practitioner Data Bank data from the past 25 years and found that “diagnostic errors [*i.e.*, diagnoses that are missed, wrong or delayed] – not surgical mistakes or medication overdoses – accounted for the largest fraction of claims, the most severe patient harm, and the highest total of penalty payouts.”⁴¹⁵ More specifically, between 1986 and 2010,

- Of the 350,706 paid claims, “diagnostic errors were the leading type (28.6 percent).”⁴¹⁶
- “The majority of diagnostic errors were missed diagnoses, rather than delayed or wrong ones.”⁴¹⁷
- “[M]ore diagnostic error claims were rooted in outpatient care than inpatient care, (68.8 percent vs. 31.2 percent) but inpatient diagnostic errors were more likely to be lethal (48.4 percent vs. 36.9 percent).”⁴¹⁸
- “Diagnostic errors resulted in death or disability almost twice as often as other error categories.”⁴¹⁹
- “[A]mong malpractice claims, the number of lethal diagnostic errors was roughly the same as the number that resulted in permanent, severe harm to patients. This suggests that the public health impact of these types of mistakes is probably much greater than previously believed because prior estimates are based on autopsy data, so they only count deaths and not disability....”⁴²⁰
- Diagnostic errors “accounted for the highest proportion of total payments (35.2 percent).”⁴²¹

- ‘Diagnosis-related payments amounted to \$38.8 billion between 1986 and 2010....’⁴²²
- “Per-claim payments were highest in cases of serious neurologic harm, including quadriplegia and brain damage resulting in the need for lifelong care. Those payments, the researchers found, were higher even than for errors resulting in death.”⁴²³
- “While the new study looked only at a subset of claims – those that rose to the level of a malpractice payout – researchers estimate the number of patients suffering misdiagnosis-related, potentially preventable, significant permanent injury or death annually in the United States ranges from 80,000 to 160,000.”⁴²⁴
- “The human toll of mistaken diagnoses is likely much greater” than this review showed because the data used “covers only cases with the most severe consequences of diagnostic error. There are many others that occur daily that result in costly patient inconvenience and suffering.... One estimate suggests that when patients see a doctor for a new problem, the average diagnostic error rate may be as high as 15 percent.”⁴²⁵

As leader researcher Dr. David E. Newman-Toker explained, “This is more evidence that diagnostic errors could easily be the biggest patient safety and medical malpractice problem in the United States.... There’s a lot more harm associated with diagnostic errors than we imagined.”⁴²⁶

“Health Care – Associated Infections,” Harvard Medical School’s Brigham and Women’s Hospital Research Associate Eyal Zimlichman, MD, MSc et al., 2013.

According to the study, published in *JAMA Internal Medicine*, hospital-acquired infections cost the U.S. health care system \$9.8 billion a year.⁴²⁷ As reported by *Reuters*, “Zimlichman and his team reviewed 26 studies to identify the costs associated with treating the five most common, expensive and preventable infections among hospitalized patients” and found the following:⁴²⁸

- “About 441,000 of these infections occur among hospitalized adults in the U.S. every year, for a total cost of \$9.8 billion....”
- “Surgical site infections and ventilator-associated pneumonia each accounted for about one third of the total costs. That was followed by central line bloodstream infections (about 19 percent), *C. difficile* infections (15 percent) and catheter-associated UTIs, which accounted for less than 1 percent of all costs.”
- “Bloodstream infections from central lines, which are long tubes inserted in a large vein such as in the chest or arm to deliver medication, fluids, nutrients or blood products, were the most expensive, at a cost of \$45,814 per case. Ventilator-associated pneumonia, or a

lung infection that develops while a person is on a respirator, came in second, at \$40,144 per case.”

- “Post-surgery infections occurring at the site of the operation cost \$20,785 per patient. Infection with *Clostridium difficile*, a tough-to-treat bacterium that causes severe diarrhea and can spread within hospital units, cost \$11,285 per case. Catheter-associated urinary tract infections (UTIs) were the least costly, at \$896 per case.”

As Dr. Peter Pronovost, director of the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine in Baltimore, told *Reuters Health*, “This study really adds further evidence that not only are these infections too common and often lethal, they’re extremely expensive.... We really need to accelerate our efforts to reduce these infections.”⁴²⁹

Sentinel Event Alert, Joint Commission, 2013.

- According to the non-profit’s report, since 2005, there have been nearly 800 incidents of surgical tools being left inside patients following a procedure.⁴³⁰ Among the objects most commonly left behind: sponges, towels, broken parts of instruments, stapler components, needles and other sharps. “These cases resulted in 16 deaths, and about 95 percent of these incidents resulted in additional care and/or an extended hospital stay,” explained the Joint Commission.⁴³¹ “Beyond the human toll, studies have shown that objects left behind after surgery may cost as much as \$200,000 per case in medical and liability payments.”⁴³²
- Why is this happening? The study found the most common root causes are: “the absence of policies and procedures, failure to comply with existing policies and procedures, problems with hierarchy and intimidation in the surgical team, failure in communication with physicians, failure of staff to communicate relevant patient information and inadequate or incomplete staff education.”⁴³³

“Surgical never events in the United States,” Johns Hopkins University School of Medicine Associate Professor of Surgery Martin Makary, M.D., M.P.H. et al., 2012

- In a groundbreaking study of NPDB data, patient safety researchers found that 4,044 surgical “never events” (*i.e.*, surgical mistakes that should never happen) occur in the United States each year. More specifically,
 - “[A] surgeon in the United States leaves a foreign object such as a sponge or a towel inside a patient’s body after an operation 39 times a week, performs the wrong procedure on a patient 20 times a week and operates on the wrong body site 20 times a week.”⁴³⁴ In other words, an estimated “80,000 of these so-called ‘never events’ occurred in American hospitals between 1990 and 2010,” a number the researchers believe is “likely on the low side.”⁴³⁵
- Between 1990 and 2010, the cost of malpractice payments for surgical “never events” totaled \$1.3 billion.⁴³⁶

Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, Institute of Medicine, 2012

- “More than a decade since the Institute of Medicine’s (IOM) *To Err Is Human: Building a Safer Health System* was published, the U.S. health care system continues to fall far short of its potential. While *To Err Is Human* and other IOM reports, including the *Crossing the Quality Chasm* series, have helped spark numerous efforts to improve practices, persistent health care underperformance and high costs highlight the considerable challenge of bringing isolated successes to scale. The nation has yet to see the broad improvements in safety, accessibility, quality, or efficiency that the American people need and deserve.”⁴³⁷
- “As with many other aspects of the health care enterprise, a variety of financial incentives and payment models are currently in use. Some are modeled on a fee-for-service structure and some on a capitated or global payment system; other models exist as well. The most common models for both public and private plans tend to pay clinicians based on the volume of individual procedures and tests. Higher-quality care rarely is rewarded by payment and contracting policies, so that there is little relationship between the cost or price of care and the quality and outcomes of the care provided (Fisher et al., 2003; Office of Attorney General of Massachusetts, 2011; Yasaitis et al., 2009). One study found, on average, only a 4.3 percent correlation (as measured by a coefficient of determination) between the quality of care delivered and the price of the medical service; indeed, higher prices often were associated with lower quality (Office of Attorney General of Massachusetts, 2011).”⁴³⁸
- “As the IOM committee reports, every missed opportunity for improving health care results in unnecessary suffering. By one estimate, almost 75,000 needless deaths could have been averted in 2005 if every state had delivered care on par with the best performing state. Current waste diverts resources; the committee estimates \$750 billion in unnecessary health spending in 2009 alone.”⁴³⁹ As the *New York Times* explains, “The institute’s analysis of 2009 data shows \$210 billion spent on unnecessary services, like repeated tests, and \$130 billion spent on inefficiently delivered services, like a scan performed in a hospital rather than an outpatient center.”⁴⁴⁰ Moreover, “It also shows the health care system wasting \$75 billion a year on fraud, \$55 billion on missed prevention opportunities and a whopping \$190 billion on paperwork and unnecessary administrative costs.”⁴⁴¹

“Transformation of Health System Needed to Improve Care and Reduce Costs,” National Academies, 2012.

- “‘The threats to Americans’ health and economic security are clear and compelling, and it’s time to get all hands on deck,’ said committee chair Mark D. Smith, president and CEO, California HealthCare Foundation, Oakland. ‘Our health care system lags in its ability to adapt, affordably meet patients’ needs, and consistently achieve better outcomes.’”⁴⁴²

- “Health care costs have increased at a greater rate than the economy as a whole for 31 of the past 40 years. Most payment systems emphasize volume over quality and value by reimbursing providers for individual procedures and tests rather than paying a flat rate or reimbursing based on patients’ outcomes, the report notes. It calls on health economists, researchers, professional societies, and insurance providers to work together on ways to measure quality performance and design new payment models and incentives that reward high-value care.”⁴⁴³

“What’s Possible for Health Care?” Institute of Medicine, 2012.

“1/3 of hospitalized patients are harmed during their stay.”⁴⁴⁴

Health Affairs, 2011.

The April 2011 edition of *Health Affairs* contained three important articles about medical errors and their costs:

“Global Trigger Tool’ Shows That Adverse Events In Hospitals May Be Ten Times Greater Than Previously Measured,” University of Utah Associate Professor of Medicine David Classen et al.

This study found that medical errors occur in one-third of hospital admissions, as much as ten times more frequently than previously estimated.⁴⁴⁵ This is because adverse event detection methods commonly used to track patient safety in the United States today — voluntary reporting and the Agency for Healthcare Research and Quality’s Patient Safety Indicators — are woefully inadequate, missing as many as 90 percent of hospital errors.⁴⁴⁶ “Hospitals that use such methods alone to measure their overall performance on patient safety may be seriously misjudging actual performance,” the researchers wrote. “Reliance on such methods could produce misleading conclusions about safety in the U.S. health-care system and could misdirect patient-safety improvement efforts.”

Chief medical mistakes uncovered in the report: “medication errors, including getting the wrong drug or being given the wrong dose of the right drug; surgical errors, such as having an operation done on the wrong site or surgical gaffes that result in bleeding or infection; and hospital-acquired infections, which often result from poor sanitation.”⁴⁴⁷ As lead researcher Dr. David C. Classen, an associate professor of medicine at the University of Utah, put it, “The more you look for errors, the more you find.”⁴⁴⁸

“The Social Cost Of Adverse Medical Events, And What We Can Do About It,” National Center for Policy Analysis.

In 2006, medical mistakes contributed to up to 6.1 million injuries and 187,135 deaths in the United States.⁴⁴⁹ Lost lives and disabilities caused by medical error cost between \$393 billion and \$958 billion in 2006, equivalent to 18-45% of total US health-care

spending in that year.⁴⁵⁰ “For every dollar that was spent in the health care system, about 18 to 45 cents of that dollar went to hurting someone,” explained co-author Pamela Villarreal in an April 7th briefing.⁴⁵¹

“The \$17.1 Billion Problem: The Annual Cost Of Measurable Medical Errors,” Milliman Inc.

An analysis of insurance claims from 2001 through 2008 found approximately 564,000 injuries to patients admitted to U.S. hospitals and 1.8 million injuries to people using outpatient services.⁴⁵² Preventable medical mistakes that harmed patients cost the United States \$17.1 billion in 2008.⁴⁵³ According to the researchers, “ten types of error account for more than two-thirds of the total cost of errors,” with the most common ones being pressure ulcers, postoperative infections and persistent back pain following back surgery.⁴⁵⁴ The single most expensive cause of harm – infection after surgery, with more than 252,000 infections costing \$3.36 billion. The most common preventable event – pressure ulcers, with nearly 375,000 cases costing \$3.27 billion.⁴⁵⁵

“Hospital Acquired Condition Rates,” Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, 2011.

Medicare claims from October 2008 through June 2010 show elderly and disabled patients suffering thousands of serious, preventable injuries in the nation’s 4,700 hospitals.⁴⁵⁶ Since October 2008, Medicare stopped reimbursing hospitals for such medical errors, known as “never events” because they should never happen.⁴⁵⁷ Errors included: 10,564 instances of falls and trauma, 6,868 catheter-associated bloodstream infections, 5,928 catheter-associated urinary tract infections, 2,521 cases of pressure ulcers (bedsores), 944 manifestations of poor glycemic control and 484 instances of foreign objects left behind during surgeries.⁴⁵⁸ “By making [hospital acquired conditions or ‘HAC’] data transparent, CMS sheds light on those preventable events where patients are harmed while seeking care,” the agency said in a press release.⁴⁵⁹

Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, Office of Inspector General, U.S. Department of Health and Human Services, 2010.

- “Of the nearly 1 million Medicare beneficiaries discharged from hospitals in October 2008, about ***1 in 7*** experienced an adverse event that met at least 1 of our criteria (13.5 percent).”⁴⁶⁰ “An estimated 1.5 percent of Medicare beneficiaries experienced an event that contributed to their deaths, which projects to 15,000 patients in a single month.”⁴⁶¹
- “Physician reviewers determined that ***44 percent of adverse and temporary harm events were clearly or likely preventable.*** ... Preventable events were linked most commonly to medical errors, substandard care, and lack of patient monitoring and assessment.”⁴⁶² “Because many adverse events we identified were preventable, our study confirms the need and opportunity for hospitals to significantly reduce the incidence of events.”⁴⁶³
- “Hospital care associated with adverse and temporary harm events cost Medicare an estimated \$324 million in October 2008. Sixteen percent of sample beneficiaries in the

Medicare Inpatient Prospective Payment System who experienced events incurred additional Medicare costs as a result. The added costs equate to an estimated 3.5 percent of Medicare's expenditure for inpatient care during October 2008. To give these figures an annual context, 3.5 percent of the \$137 billion Medicare inpatient expenditure for FY 2009 equates to **\$4.4 billion** spent on care associated with events. Two-thirds of Medicare costs associated with events were the result of entire additional hospital stays necessitated by harm from the events. Additionally, these Medicare cost estimates do not include additional costs required for follow-up care after the sample hospitalizations."⁴⁶⁴

❖ STATE-SPECIFIC ERROR TRENDS ARE SIMILAR.

- **Connecticut.** A state Department of Public Health report detailed a total of 417 adverse events in Connecticut hospitals in 2014. “The most common adverse events are: (1) stage 3-4 or unstageable pressure ulcers acquired after admission to a healthcare facility, (2) falls resulting in serious disability or death, (3) perforations during open, laparoscopic, and/or endoscopic procedures, and (4) retention of foreign objects in patients after surgery. These four categories accounted for 89% of events reported in 2014, the report states.”⁴⁶⁵

In addition, “[o]f the 471 total adverse events reported in 2014, 245 were for ulcers, 78 for falls, 70 for perforations and 24 for retention of foreign objects. Other adverse events reported include: 15 cases where surgery was performed on the patient’s wrong side, 4 times where the wrong surgical procedure was performed on a patient, and 3 times where death or serious injury was reported due to contaminated drugs or devices used.”⁴⁶⁶

“And in instances where objects were left inside patients, 9 times that involved a sponge or towel, 5 times a catheter fragment was left inside, and 3 times a guide wire piece was left inside the patient, the report states.”⁴⁶⁷

- **Indiana.** “New data released from the Indiana State Department of Health show that the state has set another record for medical errors,” with “114 preventable adverse medical incidents in hospitals and health care facilities in 2014. That’s three more than in any of the other eight years since the agency started gathering statistics. Errors have topped 100 in seven of nine years, with the previous high 111 errors in 2013.”⁴⁶⁸ The most common medical errors were “bed sores that go untended and develop into potentially lethal infections” and “leaving a foreign object inside a patient after surgery,” which happened 27 times in the past year.⁴⁶⁹
- **Massachusetts.** “Full-service hospitals in Massachusetts reported making 821 preventable errors that harmed or endangered patients last year,” including “41 instances in which an unintended object was left behind after surgery, 24 operations on the wrong part of the body, and 290 serious injuries or deaths after a fall.”⁴⁷⁰ In addition, “[t]he total number of reported incidents rose 9 percent compared with 2013, when 753 mistakes were counted.”⁴⁷¹
- **Washington.** In 2014, hospitals and other health care facilities reported a total of 483 medical errors. Among the errors cited: surgery performed on the wrong body part (30 instances), leaving a foreign object inside a patient after surgery (37 instances), falls resulting in death or serious injury (113 instances) and bed sores (225 instances).⁴⁷²

“Temporal Trends in Rates of Patient Harm Resulting from Medical Care,” Harvard Medical School Associate Professor of Medicine and Pediatrics Christopher P. Landrigan, M.D., M.P.H. et al., 2010.

- “In a statewide study of 10 North Carolina hospitals, we found that *harm resulting from medical care was common*, with little evidence that the rate of harm had decreased substantially over a 6-year period ending in December 2007.... Since North Carolina has been a leader in efforts to improve safety, a lack of improvement in this state suggests that further improvement is also needed at the national level.⁴⁷³
- “Our findings validate concern raised by patient-safety experts in the United States and Europe that harm resulting from medical care remains very common. Though disappointing, the absence of apparent improvement is not entirely surprising. Despite substantial resource allocation and efforts to draw attention to the patient-safety epidemic on the part of government agencies, health care regulators, and private organizations, the penetration of evidence-based safety practices has been quite modest. For example, only 1.5% of hospitals in the United States have implemented a comprehensive system of electronic medical records, and only 9.1% have even basic electronic record keeping in place; only 17% have computerized provider order entry. Physicians-in-training and nurses alike routinely work hours in excess of those proven to be safe. Compliance with even simple interventions such as hand washing is poor in many centers.”⁴⁷⁴

❖ SOME ASPECTS OF IN-PATIENT AND OUT-PATIENT CARE ARE PARTICULARLY UNSAFE.

Hospitals on Weekends

“Incidence of ‘never events’ among weekend admissions versus weekday admissions to US hospitals: national analysis,” University of Southern California Medical School Neurosurgery Clinical Instructor Frank J. Attenello, M.D., et al., 2015.

Researchers analyzed data from more than 350 million U.S. hospital admissions from 2002 to 2010 and found the following⁴⁷⁵:

- “Even though most admissions - 81 percent - were on weekdays, preventable complications were more common on weekends. Hospital-acquired conditions occurred in 5.7 percent of weekend admissions, compared to 3.7 percent in people admitted on weekdays.”
- As the study’s lead author told *Reuters*, ““This increased hospital-acquired condition rate is significant because we found presence of at least one hospital-acquired condition to be associated with an 83 percent likelihood of increased healthcare cost and a 38 percent increase in the likelihood of a prolonged hospital stay....””

“The ‘Weekend Effect’ in Pediatric Surgery – Increased Mortality for Children Undergoing Urgent Surgery During the Weekend,” Johns Hopkins Surgical Resident Seth D. Goldstein, M.D. et al., 2014.

According to the study, published in the *Journal of Pediatric Surgery*, “even after controlling for sex, age, race, the type of surgery and other factors, patients having a procedure on the weekend were 40 percent more likely to sustain an accidental puncture or cut, 14 percent more likely to receive a transfusion, and 63 percent more likely to die.”⁴⁷⁶

Intensive Care Units (ICUs).

- According to a 2012 study from the Johns Hopkins University School of Medicine, “as many as 40,500 critically ill patients in the United States may die annually when clinicians fail to diagnose hidden life-threatening conditions such as heart attack and stroke. The unexpectedly high frequency of deadly misdiagnosis in hospital intensive care units or ICUs was ‘surprising and alarming,’ said Dr. Bradford Winters, the lead author of the study.”⁴⁷⁷
- Specifically, “one in four patients – 28 percent – had a missed diagnosis at the time of their death. In about 8 percent of patients, the misdiagnosis was serious enough to have

caused or contributed to the patients' deaths...."⁴⁷⁸ These ICU errors are "as much as 50 percent more common than that in general hospital patients."⁴⁷⁹

Neonatal Intensive Care Unit (NICU).

"Use of Temporary Names for Newborns and Associated Risks," Montefiore Health System Patient Safety Officer and Hospital Medicine Assistant Professor Jason Adelman, M.D., M.S., et al., 2015

Researchers found that hospitals' practice of assigning temporary, non-distinct first names such as Babyboy or Babygirl to newborns resulted in a high incidence of wrong-patient errors in the Neonatal Intensive Care Unit (NICU). According to the study, which was "designed to measure wrong-patient electronic orders, there are other types of misidentification errors in NICUs that may result from the use of nondistinct first names, such as reading imaging tests or pathology specimens for the wrong patient or administering blood products to the wrong patient. One particularly concerning wrong-patient error unique to NICUs and hospital nurseries is feeding a mother's expressed breast milk to the wrong infant."⁴⁸⁰

Emergency Rooms.

The hospital location with the highest proportion of negligent adverse events (52.6 percent) is the emergency department,⁴⁸¹ where people without health insurance often go for primary care.

Skilled Nursing Units.

Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries, Office of Inspector General, U.S. Department of Health and Human Services, 2014.

- During August 2011, an "estimated 22 percent of Medicare beneficiaries experienced adverse events during their SNF stays."⁴⁸² More specifically, approximately 21,777 patients were harmed and 1,538 died due to substandard skilled nursing care in a single month.⁴⁸³
- "Physician reviewers determined that 59 percent of these adverse events and temporary harm events were clearly or likely preventable. They attributed much of the preventable harm to substandard treatment, inadequate resident monitoring, and failure or delay of necessary care."⁴⁸⁴
- "Over half of the residents who experienced harm returned to a hospital for treatment, with an estimated cost to Medicare of \$208 million in August 2011. This equates to \$2.8 billion spent on hospital treatment for harm caused in SNFs in FY 2011."⁴⁸⁵

Clinics and Doctors' Offices.

"The frequency of diagnostic errors in outpatient care: estimations from three large observational studies involving US adult populations," Michael E. DeBaakey VA Medical Center's Quality & Informatics Program Health Policy Chief and Baylor College of Medicine Associate Professor Hardeep Singh⁴⁸⁶, M.D., M.P.H. et al., 2014.

After analyzing empirical data from several published studies that examined diagnosis and follow-up visits, Singh and his associates concluded that "[a]t least one in 20 adults is misdiagnosed in outpatient clinics in the US every year, amounting to 12 million people nationwide."⁴⁸⁷ As a result, misdiagnoses pose a "substantial patient safety risk," with half of these errors being potentially harmful.⁴⁸⁸

Office-Based Surgery Adverse Event Reporting 2010-2013, New York State Department of Health, 2014.

Between 2010 and 2013, there were 2,202 adverse events reported by just under 1,000 accredited "office based surgery" practices in NY state. 257 of those 2,202 events resulted in death, meaning that a patient died from close to 12 percent of the adverse events reported.⁴⁸⁹

Hospice Care.

"Is that hospice safe? Infrequent inspections mean it may be impossible to know," Washington Post, June 26, 2014.

"The typical hospice in the United States undergoes a full government inspection about once every six years, according to federal figures, making it one of the least-scrutinized areas of U.S. health care – even though about half of older Americans receive hospice care at the ends of their lives. By contrast, nursing homes are inspected about once a year, and home health agencies every three years....

Even as the U.S. hospice industry has grown rapidly, caring for some of society's most vulnerable, the companies that provide hospice services are rarely reviewed for competency.

"It is impossible to say precisely how many hospice companies might be cited for violations if there were more scrutiny, but a significant portion of them appear to be providing scant care, Medicare statistics and interviews show.

"Another fundamental problem: Hospices can boost profits by short-changing patients. Medicare pays hospice companies per patient, per day of care. For a 'routine' day of care,

a hospice is paid about \$150, regardless of how many services it provides. That means that stinting on nurse visits, for example, could boost profit margins....”⁴⁹⁰

“Terminal neglect? How some hospices treat dying patients,” *Washington Post*, May 3, 2014.

“[A]bout one in six U.S. hospice agencies, serving more than 50,000 of the terminally ill, did not provide either form of crisis care to any of their patients in 2012, according to an analysis of millions of Medicare billing records.”⁴⁹¹

“The absence of such care suggests that some hospice outfits are stinting on nursing attention, according to hospice experts. Inspection and complaint records, meanwhile, depict the anguish of patients who have been left without care.

❖ HOSPITALS PROFIT BY PROVIDING UNSAFE MEDICAL CARE.

“Medicare Payment Policy Creates Incentives For Long-Term Care Hospitals To Time Discharges For Maximum Reimbursement,” UCLA School of Public Health Health Policy and Management Department Chair and Professor Jack Needleman, Ph.D., FAAN, et al., 2015.

Long-term-care hospitals, which specialize in treating people with serious conditions who require prolonged care,⁴⁹² “discharge a disproportionately large share of Medicare patients during a window when they stand to make the most money from reimbursements under the federal program,”⁴⁹³ not because of patients’ needs or their best interests. Based on this money-making discharge approach, “Medicare had spent \$164 million in excess reimbursements on the ventilator patients over the five-year period,” for example.⁴⁹⁴

“Hospital Discharges Rise at Lucrative Times,” *Wall Street Journal*, February 17, 2015.

After analyzing Medicare claims paid from 2008 to 2013, the *WSJ* found that “long-term hospitals discharged 25% of patients during the three days after crossing thresholds for higher, lump-sum payments. That is five times as many patients as were released the three days before the thresholds.”⁴⁹⁵

“Long-term-hospital executives sometimes pursued that goal for financial reasons rather than medical ones, say doctors, nurses and former long-term-hospital employees interviewed by the *Journal*.”⁴⁹⁶

“More than 400 long-term, acute-care hospitals in the U.S. received about \$30 billion in Medicare payments from 2008 through 2013,” the *WSJ* reported.⁴⁹⁷

“‘The pattern of discharging patients at the most lucrative juncture is ‘troubling and disturbing,’ says Tom Finucane, a doctor and professor at Johns Hopkins University School of Medicine, after learning of the *Journal*’s findings. ‘The health-care system should serve the patients and try to improve their health, and any step away from that is a corruption.’ Dr. Finucane and other medical experts say longer-than-necessary hospital stays increase risks for medical errors, infection and unnecessary care. Discharges that come too early can mean patients don’t get care they need.”⁴⁹⁸

“More than 450 hospitals pay over \$250 million in cardiac-device investigation,” *Modern Healthcare*, October 30, 2015

“More than 450 hospitals have settled with the government for more than \$250 million as part of a yearslong, nationwide investigation into the suspected overuse of implantable cardiac devices, the U.S. Justice Department announced Friday.

“The hospital systems involved include many of the country’s largest, such as Adventist, Ascension Health, Banner Health, Catholic Health Initiatives, Community Health Systems, HCA, Tenet Healthcare Corp. and Universal Health Services among others.

“At 42, HCA had the most hospitals involved in settlements and is paying the highest portion of the settlement, \$15.8 million, followed by Ascension Health with 32 settling for \$14.9 million and then Community Health Systems with 31 settling for \$13 million.”⁴⁹⁹

“Relationship Between Occurrence of Surgical Complications and Hospital Finances,” Harvard School of Public Health and Harvard Medical School Professor Atul Gawande, M.D., M.P.H., et al, 2013.

“When patients suffer from complications on the operating table, hospitals reap huge profits, according to a new study to be published Wednesday in *The Journal of the American Medical Association*.

“‘We’ve known for a while that we’re paying for quantity instead of quality, but the magnitude of the numbers behind what that meant have never been articulated,’ Dr. Atul Gawande, one of the study’s authors, said in a phone interview. ‘What we found is, they’re eye-popping.’

“Perverse financial incentives offered by private insurers and Medicare actually pad hospitals’ profits when surgeries go awry, according to the study.

“Hospitals earned 330 percent higher profit margins on surgeries with one or more complications when they were paid for by private insurers, according to the study. Surgeries with complications covered by Medicare earned 190 percent higher profit margins. That translates to approximately \$30,500 more per faulty surgery.

“The data are a gut-punch to the hospital industry at a time when health care stakeholders universally insist on reforms that pay for high-quality care, rather than quantity. It also underscores the financial risks faced by providers that might be otherwise interested in payment reform but worry it could lead to instability or job losses if they end up losing funds and resources.

“‘The more effective their quality control department is, the more they lose,’ [Gawande] said. ‘We’re talking about massive amounts of losses if they improve quality.’

“The study indicates that some movement toward bundled payments – paying hospital systems fixed rates for different types of care, regardless of whether there’s a complication – has helped reverse the incentive to leave quality issues unaddressed. But most hospitals have yet to transition to such a system.”⁵⁰⁰

❖ THE SITUATION IS FAR WORSE BECAUSE MAJOR ERRORS GO UNREPORTED.

“Enhanced Hospital Safety Score Helps Patients Track U.S. Hospitals’ Consistency in Preventing Harm,” Leapfrog Group, 2015.

“[P]erformance on safety outcomes – including preventing errors, accidents and infections – has not significantly improved,”⁵⁰¹ with 40 percent of the 2,523 hospitals analyzed receiving a C, D or F grade.

2014 National Healthcare Quality and Disparities Report, Agency for Healthcare Research and Quality, 2014.

“On average, less than half of respondents within hospitals (44 percent) reported at least one [medical error] in their hospital over the past 12 months. It is likely that this represents underreporting of events,”⁵⁰² which “means potential patient safety problems may not be recognized or identified and therefore may not be addressed.”⁵⁰³

“Medical Harm: Patient Perceptions and Follow-up Actions,” Johns Hopkins University School of Medicine Professor of Surgery Marty Makary, M.D., M.P.H. et al., 2014

According to the study, published in the *Journal of Patient Safety*, it’s rare for medical providers to voluntarily disclose errors to patients. Among the key findings:⁵⁰⁴

- “It was common for health care providers to withhold information about medical mistakes. Only 9 percent of patients said the medical facility voluntarily disclosed the harm.”
- “When officials did disclose harm it was often because they were forced to. Nine percent of respondents said the harm was only acknowledged under pressure.”
- “More than 30 percent reported paying bills related to the harm. The average cost: \$14,024.”

Hospital Incident Reporting Systems Do Not Capture Most Patient Harm and Few Adverse Events in Hospitals Were Reported to State Adverse Event Reporting Systems, Office of Inspector General, U.S. Department of Health and Human Services, 2012.

- According to a January 2012 study, “Hospital employees recognize and report only one out of seven errors, accidents and other events that harm Medicare patients while they are hospitalized.” This massive error “underreporting” problem at hospitals is because hospitals employees do not seem to know what patient harm is and if they do, they think

it is someone else's job to report it. Specifically, "[T]he problem is that hospital employees do not recognize 'what constitutes patient harm' or do not realize that particular events harmed patients and should be reported.... In some cases ... employees assumed someone else would report the episode, or they thought it was so common that it did not need to be reported, or 'suspected that the events were isolated incidents unlikely to recur.'"⁵⁰⁵

- A July 2012 follow-up study found that "[a]lthough half of States operated adverse event reporting systems in 2008, hospitals reported few events to State systems. For all but one event that was not reported to State systems as required, the hospitals did not identify the events within internal incident reporting systems. This indicates that low reporting to State systems is more likely to result from hospital failure to identify events than from hospitals' neglecting to report known events."⁵⁰⁶

Moreover, "[m]any of the events not reported to State systems as required involved serious harm to hospitalized Medicare beneficiaries. Six of the thirty-two events contributed to patient death, including cases involving lack of patient monitoring and missed diagnoses.... Other unreported events required the use of life-sustaining interventions, indicating that hospital staff were clearly alerted to a problem but still did not report the events."⁵⁰⁷

"Further, the less serious, temporary harm events that hospitals did not report included many events that can become serious if not ameliorated, such as excessive bleeding and intravenous volume overload. The treatment required to stop the progression of these events also implies that in each case, hospital staff were likely aware of the patient's condition but did not perceive the condition as an event."⁵⁰⁸

"Year after report, patients still face risks," *Albany Times Union*, 2010.

- A September 2010 *Hearst* newspapers investigation revealed that most states fail to report medical errors.⁵⁰⁹ According to the study, "Twenty-three states don't have a medical-error detection program. Even those with mandatory programs miss a majority of the harm."⁵¹⁰
- "Outside of New York and Pennsylvania, which have robust error reporting systems, a Hearst sampling showed other states with mandatory programs didn't account for between 97 percent and 75 percent of harmful events — based on a conservative definition of harm."⁵¹¹

State-specific error reporting problems.

- **California.** "Eighty-seven hospitals – more than 20% of the 418 hospitals covered under a law that took effect in 2007 – have made no reports of medical errors, according to the California Department of Public Health."⁵¹²

- Nevada.** After examining 425,000 billing records in 2008 and 2009, the *Las Vegas Sun* “identified 3,689 cases of preventable harm that could be categorized as sentinel events, meaning Nevada law requires them to be reported to the state.”⁵¹³ According to the *Sun*, “During those same two years, all Nevada hospitals reported just 402 sentinel events.”⁵¹⁴ “In its investigation, the *Sun* found that at the 13 acute-care hospitals in the Las Vegas Valley in 2008-09, there were: 710 surgical accidents; 2,010 cases where patients were infected with lethal bacteria; 969 cases of injuries such as bloodstream infections involving central-line catheters, advanced-stage pressure sores and postoperative falls.”⁵¹⁵
- North Carolina.** “Most medical centers continue to depend on voluntary reporting to track institutional safety, despite repeated studies showing the inadequacy of such reporting.”⁵¹⁶
- Texas.** According to a 2009 investigative series by Hearst newspapers,⁵¹⁷ after Texas enacted its cap on non-economic damages, “the number of complaints against Texas doctors to the Medical Board rose from 2,942 to 6,000 in one year. More than half of those complaints were about the quality of medical care.”⁵¹⁸ Yet, “Texas has fumbled attempts to establish a medical error reporting system, often leaving patients to discover errors the hard way — when a mistake costs them their livelihood or the life of a loved one.”⁵¹⁹ “In 2003, Texas hospitals were asked to report just nine broadly defined error categories. The Texas data kept from 2003 to 2007 kept hospital names secret. Only error totals were made available to the public.”⁵²⁰ The data on the Texas Department of State Health Services’ Web site is minimal and suspiciously low and “[f]amilies of patients found the general nature of the reporting infuriating.”⁵²¹ What’s more, in 2003, “the Texas lawmakers established the fledgling Office of Patient Protection, designed to respond to complaints from the public not handled by the Medical Board.”⁵²² But, “it never got the chance to work. The Legislature eliminated the agency in 2005 and, without resistance from the hospital lobby, eliminated the error reporting system in 2007.”⁵²³
- Washington.** The Hearst investigation found that, thousands are “harmed each year by medical care in Washington hospitals, some fatally and some suffering serious disabilities” and that even “[t]hrough Washington is one of 27 states that require hospitals and other facilities to report serious medical errors, just a fraction [of] the errors that likely happen here are reported.”⁵²⁴ “[T]here are likely at least 2,200 reportable incidents a year in Washington.”⁵²⁵ In 2009, facilities reported only 198 to the Washington health department.⁵²⁶ “Washington’s medical error reporting program isn’t able to enforce the reporting law because it’s underfunded and lacks enforcement powers – and because the rules laying out which incidents must be reported make it easy for hospitals to rule that an error isn’t a ‘reportable error.’”⁵²⁷ “Nearly 7,000 patients spent 29,000 days at Yakima Regional last year; it is one of the largest facilities in the state that hasn’t filed any adverse event reports since the law went into effect in June 2006.”⁵²⁸ “Washington’s 162 walk-in surgery centers were added to the list of facilities required to report this year. In the first two quarters of 2010 only four of them have reported a total of five adverse events. Experts say that number is also incredibly low based on the volume of work being done in these facilities, which do more than 340,000 surgical procedures each year.”⁵²⁹

❖ MOST PATIENTS WORRY ABOUT MEDICAL ERRORS.

Wolters Kluwer Health Survey, 2012.

- “Nearly three-quarters [73 percent] of patients say they are concerned about the potential for medical errors, according to a poll that sheds light on public perceptions of patient safety.”⁵³⁰
- “Three in 10 patients said they had experience with a medical error, either personally or through a close friend or family member.”⁵³¹
- “Twenty-one percent reported having been misdiagnosed by a physician....”⁵³²

❖ PATIENT SAFETY IS SUFFERING BECAUSE SO FEW INJURED PATIENTS SUE.

“The Empirical Effects of Tort Reform,” Cornell University Law School Professor Theodore Eisenberg, 2012.

“One possible factor contributing to the continued high rate of errors is that doctors do not expect to bear the full cost of harms caused by their negligence. Studies of medical error consistently find that the vast majority of patients injured by medical error do not file a claim (Weiler et al. 1993; Sloan et al. 1995; Andrews, 2006). Those that do sue often do not recover. Beyond this, hospitals do not bear the full costs of the harms caused in them even though hospitals directly and indirectly influence patients’ risk of medical error (Mello et al. (2007)).”⁵³³

The Medical Malpractice Myth, University of Pennsylvania Law School Professor Tom Baker, 2005.

“[T]here are far more cases of medical malpractice than medical malpractice litigation. Professor Danzon reported that there were 10 incidents of medical malpractice for every one malpractice claim in the United States. The Harvard group found a seven-to-one ratio in New York and Colorado and a five-to-one ratio in Utah. Because hospital record reviews miss so much medical malpractice, the real multiple is much higher.

...

“[T]he Harvard team looked at about 30,000 hospital records in New York and found conclusive evidence of a serious injury from medical malpractice in the records of 280 patients. How many of those 280 patients brought a claim? Eight. That is less than 3 percent.

“In Utah and Colorado, the team looked at about 15,000 hospital records and found conclusive evidence of a serious injury from medical malpractice in the records of 161 patients. How many of those 161 patients brought a claim? Four. That is also less than 3 percent.”⁵³⁴

Empirical Studies, National Center for State Courts, 2011.

- An October 2011 study found that “[m]ost incoming medical malpractice caseloads are down over the last 10 years.”⁵³⁵ More specifically, from 2000 to 2009, med mal filings fell by 18 percent in the general jurisdiction courts of 7 states reporting.⁵³⁶ In 5 of those states, filings fell by between 18 and 42 percent.⁵³⁷ These findings are consistent with an April 2011 National Center for State Courts report, which concluded that “[c]ontrary to the claims of some tort reform advocates, medical malpractice caseloads have been decreasing over time.”⁵³⁸
- Moreover, according to that April 2011 report, “despite the widespread prevalence of medical negligence,”⁵³⁹ in 2008 medical malpractice case filings “represented well under 2 percent of all incoming civil cases, and less than 8 percent of incoming tort cases”⁵⁴⁰ in the general jurisdiction courts of 12 states reporting.

❖ LITIGATION IMPROVES PATIENT SAFETY WHILE “TORT REFORM” LAWS HARM IT.

“The Deterrent Effect of Tort Law: Evidence from Medical Malpractice Reform,” Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black and Northwestern University Department of Economics Ph.D. Candidate Zenon Zabinski, 2014.

The authors examined five states that enacted caps during the last “hard” insurance market (2003 to 2005)⁵⁴¹ where standard Patient Safety Indicators (PSIs)⁵⁴² were also available for at least two years before caps passed (to allow for comparison). They then compared these data to other “control” states. They found “consistent evidence that patient safety generally falls” after caps are passed.⁵⁴³ Specifically:

- “We find a gradual rise in rates for most PSIs after [caps were passed], consistent with a gradual relaxation of care, or failure to reinforce care standards over time.”⁵⁴⁴
- “The decline is widespread, and applies both to aspects of care that are relatively likely to lead to a malpractice suit (e.g., ... foreign body left in during surgery), and aspects that are unlikely to do so (e.g., ... central-line associated bloodstream infection).”⁵⁴⁵
- “The broad relaxation of care suggests that med mal liability provides ‘general deterrence’ – an incentive to be careful in general – in addition to any ‘specific deterrence’ it may provide for particular actions....”⁵⁴⁶
- “We find evidence that reduced risk of med mal litigation, due to state adoption of damage caps, leads to higher rates of preventable adverse patient safety events in hospitals.”⁵⁴⁷

“A Dose of Reality for Medical Malpractice Reform,” UCLA Law Professor Joanna C. Schwartz, 2012.

After conducting in-depth interviews and a nationwide survey of those responsible for risk management, claims management and quality improvement in hospitals around the country, Acting UCLA Law Professor Joanna C. Schwartz found that malpractice lawsuits enhance patient safety.⁵⁴⁸ As Schwartz explained in an August 2012 study, “malpractice lawsuits are playing an unexpected role in patient safety efforts: as a source of relevant information about medical error. The vast majority of interviewees and survey participants report that their hospitals review legal claims, the information developed during the course of discovery, and closed claims for patient safety lessons.”⁵⁴⁹ Moreover, “litigation data has proven useful to hospital patient safety efforts. Lawsuits reveal allegations of medical negligence and other patient safety issues about which hospital were previously unaware; depositions and discovery materials surface previously

unknown details of adverse events; analyses of claim trends reveal problem procedures and departments; and closed claims files serve as rich teaching tools.”⁵⁵⁰

“The Patient’s Right to Safety – Improving the Quality of Care through Litigation against Hospitals,” George J. Annas, J.D., M.P.H., 2006.

“In the absence of a comprehensive social insurance system, the patient’s right to safety can be enforced only by a legal claim against the hospital. ... [M]ore liability suits against hospitals may be necessary to motivate hospital boards to take patient safety more seriously.... Anesthesiologists were motivated by litigation to improve patient safety. As a result, this profession implemented 25-years-ago a program to make anesthesia safer for patients and as a result, the risk of death from anesthesia dropped from 1 in 5000 to about 1 in 250,000.”⁵⁵¹

“The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?” University of Illinois Professor of Law and Medicine David A. Hyman and University of Texas Law Professor Charles Silver, 2005.

- The field of surgical anesthesia, where anesthesiologists adopted practice guidelines to reduce deaths, injuries, claims and lawsuits, is a strong case in point. Hyman and Silver write: “[T]wo major factors forced their hand: malpractice claims and negative publicity.... Anesthesiologists worked hard to protect patients *because* of malpractice exposure, not in spite of it.”⁵⁵²
- As Hyman and Silver explain in a later paper, the reason why tort liability promotes patient safety is obvious: Providers are rational. When injuring patients becomes more expensive than not injuring them, providers will stop injuring patients.⁵⁵³

Lifesavers, Center for Justice & Democracy, 2002.

Numerous other medical practices have been made safer only after the families of sick and injured patients filed lawsuits against those responsible. In addition to anesthesia procedures, these include catheter placements, drug prescriptions, hospital staffing levels, infection control, nursing home care and trauma care.⁵⁵⁴ As a result of such lawsuits, the lives of countless other patients have been saved.

Harvard Medical Practice Study, 1991.

“[T]he litigation system seems to protect many patients from being injured in the first place. And since prevention before the fact is generally preferable to compensation after the fact, the apparent injury prevention effect must be an important factor in the debate about the future of the malpractice litigation system.”⁵⁵⁵

❖ “FEAR OF LITIGATION” IS NOT THE MAIN REASON DOCTORS FAIL TO REPORT ERRORS.

Hospital Incident Reporting Systems Do Not Capture Most Patient Harm, Office of Inspector General, U.S. Department of Health and Human Services, 2012.

As noted earlier, a January 2012 report from the U.S. Department of Health and Human Services (HHS) found that massive error underreporting at hospitals is caused by widespread employee failure to recognize patient harm.⁵⁵⁶ According to the HHS Inspector General, “[T]he problem is that hospital employees do not recognize ‘what constitutes patient harm’ or do not realize that particular events harmed patients and should be reported. In some cases, he said, employees assumed someone else would report the episode, or they thought it was so common that it did not need to be reported, or ‘suspected that the events were isolated incidents unlikely to recur.’”⁵⁵⁷

“Choosing Your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients,” University of Washington Internal-Medicine Physician Thomas Gallagher et al., 2006.

According to a 2006 study published in the *Archives of Internal Medicine*, comparisons of how Canadian and U.S. doctors disclose mistakes point to a “culture of medicine,”⁵⁵⁸ not lawyers, for their behavior. In Canada, there are no juries, non-economic awards are severely capped and “if patients lose their lawsuits, they have to pay the doctors’ legal bills,”⁵⁵⁹ “yet doctors are just as reluctant to fess up to mistakes.”⁵⁶⁰ Moreover, “doctors’ thoughts on how likely they were to be sued didn’t affect their decisions to disclose errors.”⁵⁶¹ The authors believed “the main culprit is a ‘culture of medicine,’ which starts in medical school and instills a ‘culture of perfectionism’ that doesn’t train doctors to talk about mistakes.”⁵⁶²

“The Patient’s Right to Safety – Improving the Quality of Care through Litigation against Hospitals,” George J. Annas, J.D., M.P.H., 2006.

Research by Annas “found that only one quarter of doctors disclosed errors to their patients,”⁵⁶³ but “the result was not that much different in New Zealand, a country that has had no-fault malpractice insurance”⁵⁶⁴ (*i.e.*, no litigation against doctors) for decades. In other words, “[t]here are many reasons why physicians do not report errors, including a general reluctance to communicate with patients and a fear of disciplinary action or a loss of position or privileges.”⁵⁶⁵

❖ “TORT REFORM” INTERFERES WITH PATIENT SAFETY INITIATIVES.

“The Empirical Effects Of Tort Reform,” Cornell University Law School Professor Theodore Eisenberg, 2012.

“Evidence suggests that greater savings to hospitals and insurers can be achieved not at the expense of patient victims. ... Caps that reduce premiums by brute force likely discourage more painstaking but socially desirable efforts to improve safety.”⁵⁶⁶

CBO’s Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice (“Tort Reform”), Congressional Budget Office, 2009.

The Congressional Budget Office (CBO), in an October 2009 analysis (in the form of a 7-page letter to Senator Orin Hatch), said, “The [medical malpractice] system has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for their losses....”⁵⁶⁷ CBO wrote that “imposing limits on [the right to sue for damages] might be expected to have a negative impact on health outcomes.” Of the three studies that address the issue of mortality that it examined, CBO noted that one study found tort system restrictions would lead to a .2 percent increase in the nation’s overall death rate. If true, that would be an additional 4,874 Americans killed every year by medical malpractice, or 48,740 Americans over the 10-year period CBO examines.⁵⁶⁸ Moreover, based on these same numbers, another 400,000 or more patients could be injured during the 10 years that CBO examined (given that one in 10 injured patients die⁵⁶⁹).

PART 6: SPECIAL PROBLEMS FOR VETS AND MILITARY FAMILIES

VA Health Care: Actions Needed to Assess Decrease in Root Cause Analyses of Adverse Events, U.S. Government Accountability Office, 2015

According to the July report, medical errors in the VA system increased by 7 percent from fiscal year 2010 to fiscal year 2014, “a jump that roughly coincided with 14 percent growth in the number of veterans getting medical care through VA’s system.”⁵⁷⁰

“Newly released VA reports include cases of harm, death,” Gannett Wisconsin Media, April 29, 2015.

“Almost 140 previously unreleased investigative reports by the inspector general at the Veterans Affairs Department offer a litany of instances of dysfunction or mistreatment of veterans at VA facilities across the country and show that in many cases, the department’s chief watchdog trusted the VA to correct problems on its own rather than make findings public.”⁵⁷¹

“Service Members Are Left in Dark on Health Errors,” New York Times, April 19, 2015.

“[T]he nation’s 1.3 million active-duty service members are in a special bind, virtually powerless to hold accountable the health care system that treats them.

“They are captives of the military medical system, unable, without specific approval, to get care elsewhere if they fear theirs is substandard or dangerous. Yet if they are harmed or die, they or their survivors have no legal right to challenge their care, and seek answers, by filing malpractice suits.

“Only 18 months ago did the Pentagon explicitly allow them to file complaints about their treatment, although some had done so earlier. But even then they are barred from learning the results of any inquiry. Under federal law, investigations at military hospitals and clinics are confidential, in part to keep the findings from the roughly two million civilian patients they treat per year – spouses and children of service members, retirees and others – who can and do file malpractice claims.

[S]ervice members make up one-fifth of inpatients and one-fourth of the maternity cases at military hospitals. Yet from 2003 to 2009, the military reported just 15 clinicians for substandard care of active-duty patients, while reporting 710 clinicians – 47 times as many – for unacceptable care of civilian patients leading to a payment.⁵⁷²

“More Than 500 Vets Died at VA Hospitals Due to Mistakes Since 2010,” *Washington Free Beacon*, December 23, 2014.

“More than 500 military veterans died because of serious mistakes at Veterans Affairs hospitals across the country between 2010 and 2014, VA records show.”⁵⁷³

“Veterans exposed to viruses, claim V.A. avoided responsibility,” *MSNBC*, December 19, 2014.

- Over 6,380 patients were deemed at risk for life-threatening infections after exposure to misconfigured or unclean colonoscopy equipment at a Tennessee V.A. facility between April 23, 2003 and December 1, 2008.⁵⁷⁴
- 3,260 veterans received warning letters about the potential for serious infections after a Miami V.A. medical center failed to properly clean colonoscopy equipment between procedures from May 2004 until Feb. 12, 2009.⁵⁷⁵

“Smaller Military Hospitals Said to Put Patients at Risk,” *New York Times*, September 2, 2014.

According to a *NYT* investigation, “Military hospitals perform worse than leading civilian hospitals in most safety categories involving maternity patients.”⁵⁷⁶ For example, the rate of trauma to an infant during birth was 95 percent higher in military hospitals than civilian hospitals.

“In Military Care, a Pattern of Errors but Not Scrutiny,” *New York Times*, June 28, 2014.

According to the paper’s investigation,⁵⁷⁷

- “[M]andated safety investigations often go undone: From 2011 to 2013, medical workers reported 239 unexpected deaths, but only 100 inquiries were forwarded to the Pentagon’s patient-safety center, where analysts recommend how to improve care. Cases involving permanent harm often remained unexamined as well.
- “At the same time, by several measures considered crucial barometers of patient safety, the military system has consistently had higher than expected rates of harm and complications in two central parts of its business – maternity care and surgery.
- “From 2006 to 2010, the government paid an annual average of more than \$100 million in military malpractice claims from surgical, maternity and neonatal care, records show. It would be paying far more if not for one salient reality of military health care: Active-duty service members are required to use military hospitals and clinics, but unlike the

other patients, they may not sue. If they could, the Congressional Budget Office estimated in 2010, the military's paid claims would triple."

**"Veterans Affairs Falls Short On Commitment To Women's Medical Issues,"
Associated Press, June 22, 2014.**

According to an *AP* review of VA internal documents, inspector general reports and interviews,⁵⁷⁸ "Nationwide, nearly one in four VA hospitals does not have a fulltime gynecologist on staff. And about 140 of the 920 community-based clinics serving veterans in rural areas do not have a designated women's health provider, despite the goal that every clinic would have one."

**Friendly Fire: Death, Delay & Dismay at the VA, U.S. Senator Tom Coburn (R-Okla.),
M.D., 2014.**

- "Thousands of veterans have been subjected to Veterans Administration services that were inappropriate and insufficient or provided too late or not at all. Nearly 1,000 veterans' deaths have been linked to this kind of substandard care, with thousands of others impacted in similar ways at VA facilities around the country. Many cases involved patients suffering serious maladies, from hearing loss to mental illness to cancer."⁵⁷⁹:
- "At least 82 vets died or suffered serious injuries as a result of delayed diagnosis or treatment for colonoscopies or endoscopies at VA facilities."
- "Since 2001, the VA has paid out a total of \$36.4 million to settle 167 claims in which the words 'delay in treatment' were used to describe the alleged malpractice. While this represents a small portion of the \$845 million in malpractice costs, it indicates that at least \$36 million could have been directed to actually care for veterans if it did not have to cover the costs of the VA's shortcomings."

**"VA pays out \$200 million for nearly 1,000 veterans' wrongful deaths," Center for
Investigative Reporting, April 3, 2014.**

"In the decade after 9/11, the U.S. Department of Veterans Affairs paid \$200 million to nearly 1,000 families in wrongful death cases," with victims "ranging from decorated Iraq War veterans who shot or hanged themselves after being turned away from mental health treatment, to Vietnam veterans whose cancerous tumors were identified but allowed to grow, to missed diagnoses, botched surgeries and fatal neglect of elderly veterans."⁵⁸⁰

“VA’s Malpractice Tab: \$845M in 10 Years,” Cox Media Group, 2013.

- A nationwide investigation revealed that “taxpayers spent more than \$800 million paying 4,426 veterans and their family members who brought malpractice claims against the VA medical system since 2003.”⁵⁸¹ In 2012, a total of 454 financial settlements and awards added up to \$98.3 million.”⁵⁸²
- As reported by the *Dayton Daily News*, under federal rules, VA doctors and administrators can’t be sued, and the money to pay claims doesn’t come out of the VA budget.⁵⁸³ ““The VA likes to say they’re accountable. I don’t believe the word even exists in the VA dictionary,” said Rep. Jeff Miller (R-Fla.), Chair of the House Committee on Veterans Affairs.”⁵⁸⁴
- Rep. Phil Gingrey (R-Ga.) made a similar statement about VA physician accountability. ““They’re not worried about losing their medical license, or worried about their hospital privileges being suspended, or their contract to work in that facility not being renewed, which is all applicable in the private sector,” Gingrey explained.”⁵⁸⁵

“VA’s Malpractice Tab: \$845M in 10 Years,” Cox Media Group, 2013.

- “While being protected from malpractice lawsuits, VA doctors, nurses and administrators routinely receive pay raises and transfers the same year they are found to have provided substandard care.”⁵⁸⁶
- “Federal auditors looked at records from VA centers in Georgia, Maine, Texas and Washington and found several examples of providers who made mistakes still getting bonuses. They included:
 - A radiologist who failed to read mammograms competently, but received a bonus of \$8,216.
 - A surgeon who received \$11,819 after he was suspended without pay for two weeks for leaving a surgery early.
 - A physician who refused to see emergency room patients in the order they were given to him, leaving some waiting more than 6 hours, but he got a \$7,500 bonus.
 - A physician who practiced with an expired license for three months but received a \$7,663 bonus.”⁵⁸⁷
- “Bonuses also went to VA hospital administrators who oversaw massive failures at their medical centers. They included:

- The man who oversaw the Pittsburgh VA during a legionnaires outbreak that led to five veterans dying and 21 becoming ill, received a \$62,895 service award shortly after the outbreak was revealed.
- An Atlanta VA Medical Center director pocketed a \$13,000 bonus in 2011 and another \$17,000 worth of salary bonuses in 2010 while an audit found management problems contributed to two veterans committing suicide.
- The director of the Dayton VA Medical Center received an \$11,874 bonus in 2010 and was transferred to a headquarters job in 2011 following revelations that a dentist there failed to change gloves and sterilize equipment between procedures for more than a decade, putting possibly thousands of veterans at risk.”⁵⁸⁸

““They use bonuses like handing out candy at the VA,”” explained Rep. Jeff Miller (R-Fla.), Chair of the House Committee on Veterans Affairs. ““You usually discipline somebody by removing them from the position that they’re in, and that’s not the VA’s modus operandi. They move them to another hospital somewhere....certainly having them feel the pain of these settlements or these awards being given out, I think is probably the only step that’s going to make a difference.””⁵⁸⁹

NOTES

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