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EXPOSING MEDICAL MYTHS: “CAPS” AND PHYSICIAN SUPPLY

Joanne Doroshov, Executive Director

August 21, 2013



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EXECUTIVE SUMMARY

- The suggestion that doctors might leave California or abandon certain specialties if the \$250,000 cap on non-economic damages were repealed, let alone simply increased for inflation, has no support in the academic literature, government studies, or the actual experiences of other states.
- There are years of studies showing no correlation between where physicians decide to practice and the malpractice environment, including malpractice insurance rates and state tort law.
- No state in the nation has as much protection for doctors against excessive rate hikes and price-gouging by insurers as does California. But even in states without this strong insurance regulatory protection, the evidence clearly shows that that physician supply and the malpractice environment – whether the issue is litigation or insurance - are not linked.
- In Texas, the 2003 enactment of caps on compensation for injured patients has had no effect on physician supply. In fact, according to the latest academic research, the rate of increase in Texas of physicians engaged in direct patient care was lower after caps passed, and two specialties (OB/GYN and orthopedic surgery) grew more quickly before caps were enacted than after. Moreover, Texas is currently facing an urgent doctor shortage, likely due to the large number of uninsured in the state.
- New York State, which does not cap compensation for injured patients, has among the highest number of doctors per capita in the nation, both generally and for high-risk

specialties like OB/GYN's and surgery. The main reasons physicians leave New York are: proximity to family; inadequate salary; and visa issues. The cost of malpractice insurance is practically dead last on the list of possible reasons that any physician might leave New York State.

- In 2003, the U.S. General Accounting Office examined allegations by the American Medical Association and other doctor groups, that “access to care” problems were pervasive and related to liability concerns. The GAO found that these allegations were “inaccurate” and “not substantiated,” and that to the extent there are a few access problems, many other explanations could be established “unrelated to malpractice.”
- A 2009 report showed more than twice the number of doctors per capita in White Plains, NY than in Bakersfield, CA. “Quality of life” issues explained this disparity. Lifestyle considerations are typically the most important factors for determining a physician’s choice of specialty, as well.
- Research shows that physician shortages correlate to stagnating local economies and decreasing populations in those regions, not to lawsuits or insurance rates. Indeed, Texas researchers recently found, as have many others, that “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.”



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Where doctors choose to practice and live has no connection to a state’s tort law. That has been the finding of every credible academic and government study that has examined this issue. This includes whether or not a state caps damages and at what level. The suggestion that doctors might leave California or abandon certain specialties if the \$250,000 cap on non-economic damages were repealed, let alone simply increased for inflation, has no support in the academic literature, government studies, or actual experiences of other states.

THE TEXAS EXPERIENCE

When discussing the medical liability system, “access to care” arguments tend to be discussed in hyped-up fear-mongering terms, not facts. “Who Will Deliver Your Baby?” was the headline of a glossy Texas brochure in 2003, with medical societies arguing that the only way to solve doctor shortages in Texas was for patients to enact a MICRA-like cap, which voters proceeded to do. But as has been repeatedly shown since the *Texas Observer* first pointed it out in 2007 in the article “Baby, I Lied”,¹ not only did doctors not return to the state’s underserved areas after the cap was enacted, they never came back to the state at all. And today, the state of Texas is facing such a critical physician shortage that the legislature has taken up emergency legislation to solve it.²

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Texas' physician supply has been closely studied by Professor Bernard S. Black, Northwestern University School of Law, Northwestern University Kellogg School of Management and the European Corporate Governance Institute (ECGI); David A. Hyman, University of Illinois College of Law; and Charles Silver, University of Texas School of Law. In their most recent study³, these authors found that enactment of caps on compensation for injured patients, which Texas passed in 2003, has had no effect on physician supply.⁴ The methodology for 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.⁵

Specifically, the authors found the following:

- "[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."⁶
- [T]he rate of increase in Texas of [direct patient care, or] DPC physicians per capita was *lower* after reform."⁷ (emphasis added.)
- "[T]ort reform did not solve Texas' physician supply issues."⁸
- **Specialists.** Two specialties (ob-gyn and orthopedic surgery) *grew more quickly before tort reform than after.* (emphasis added.) Only a third specialty (neurosurgery) grew more quickly after caps passed, keeping up with population. In other words, "claims of dramatic post-reform inflows of ob-gyns, orthopedic surgeons, or neurosurgeons are unfounded."⁹
- **Primary care physicians.** "The 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)."¹⁰
- **Rural areas.** "[T]here is no evidence that tort reform materially affected the supply of DPC physicians, specialists, or physicians practicing in rural areas. These findings should not be surprising – they are generally consistent with prior multi-state studies of the relationship between tort reform and physician supply."¹¹

THE NEW YORK EXPERIENCE

In 2007, the Center for Justice & Democracy's Executive Director Joanne Doroshow was a member of the New York Governor's Task Force examining medical malpractice issues. The state medical society and specialty groups, like the American College of Obstetricians and Gynecologists (ACOG), were lobbying heavily for a MICRA-like cap, as they have done for many years. Their efforts failed then and continue to fail. But with the attention on medical malpractice in 2007, these issues were the focus of much research and analysis. As part of this

effort, it became clear that ACOG was making untrue statements about doctor shortages in New York State, which were similar to falsehoods conveyed to Texas residents four years prior, and continue to be false in New York.

The Center for Health Workforce, part of the School of Public Health, University at Albany, State University of New York- an academic institution that monitors physician supply - testified before the Task Force on October 15, 2007. The Center found that the number of OB-GYN's in New York State had been stable for the prior decade and between 2005 and 2006, the number of physicians doing obstetrics *increased* – all while birth rates were dropping in New York State.¹²

Overall Change in OB-GYN Supply from 2005 to 2006

	Physicians	Physicians per 100K population	Full Time Equivalent (FTE)	FTEs per 100K population
Obstetrics and/or Gynecology	+310	+2	+319	+2
Obstetrics and Gynecology	+238	+1	+270	+2
Gynecology	+72	No Change	+48	No Change

The Center for Health Workforce Studies also found that between 2000 and 2005, the number of obstetricians in relation to the state's birthrate grew by 2.4 percent. The Center found, "demographic changes appear to be contributing to a reduction in demand for some obstetrical services in New York."¹³

These data were similar to those released in October 2004 by NYPIRG, the Center for Medical Consumers and Public Citizen in a study entitled, *The Doctor Is In: New York's Increasing Number of Doctors*. Some of the report's key physician supply findings were as follows:

- New York State has the second highest per capita number of doctors in the nation, with the pool of doctors growing at a significantly higher rate than the state's overall population. From 1995 through 2003, the number of active physicians practicing in New York increased 16.4%. During the period 1990 through 2000, the state's population grew a mere 5.5%.
- National data shows that the number of physicians per capita is increasing faster in New York than nationally. According to the New York State Conference of Blue Cross and Blue Shield Plans, between 1980 and 2001 the national physician to population ratio had grown by 46.6% while in New York the ratio increased 47.5%.
- New York is among the top states for physicians practicing in the "high-risk" specialties of OB/GYN and surgery. New York has the fourth highest number of OB/GYNs per capita in the country. The per capita number of New York general surgeons is second highest in the nation and New York has the highest per capita number of surgical specialists.

- New York State is adding physicians in rural areas at an even faster rate than in metropolitan areas. Between 1991 and 2001, the number of physicians practicing in nonmetropolitan New York increased by 18.8%, and by 12.3% in metropolitan areas, according to the U.S. Government Accountability Office (GAO), the non-partisan investigative arm of Congress.
- The number of specialists in nonmetropolitan New York increased at an even faster rate than in metropolitan New York. Between 1991 and 2001, the number of specialists practicing in nonmetropolitan areas of New York increased by 26.9% compared with 14% in metropolitan areas.
- Physician shortages that exist in New York’s rural areas are longstanding and correlate to stagnating local economies and decreasing populations in those regions, not to lawsuits or the legal system. Population growth in all of New York was 5.5% from 1990 to 2000, but *declined* .5% in western and northern New York – areas that contain the most rural parts of the state. The number of people in New York aged 20-to-34 – the prime child-bearing ages – declined 5.4% throughout the state from 1990 to 2000 but dropped 23.1% in western and northern New York. Moreover, employment growth and wage growth were both much more sluggish in western and northern New York than in the entire state during that period.

While ob-gyn supply is not declining in New York, some physicians do leave; however, the reasons have nothing to do with malpractice. The following chart from the Center for Health Workforce Studies shows that the main reasons physicians leave the state are: proximity to family; inadequate salary; and visa issues. For non-primary care physicians, no more than three percent leave due to the cost of malpractice insurance – practically dead last on the list of possible reasons for leaving New York State.¹⁴

**Principal Reason for Doctors Leaving New York
After Completion of Residency/Fellowship**

Reason for Leaving New York	Primary Care	Non Primary Care	Total
Overall Lack of Jobs	8%	5%	6%
Lack of Jobs that Met Visa Requirements	15%	3%	7%
Lack of Jobs in Desired Locations	4%	5%	4%
Lack of Jobs in Desired Practice Settings	3%	5%	4%
Inadequate Salary Offered	19%	22%	21%
Cost of Malpractice Insurance	1%	3%	2%
Lack of Jobs for Spouse/Partner	1%	2%	1%
Proximity to Family	20%	29%	26%
Climate	4%	4%	4%
Never Intended to Practice in New York	15%	11%	12%
Other	12%	11%	12%
Total	100%	100%	100%

Physician shortages correlate to stagnating local economies and decreasing populations in those regions, not to lawsuits or insurance rates. This has been clear in New York State. For example, Oswego County reported great difficulty attracting physicians because of the “weather factor” and other lifestyles issues, including “boredom.” Another problem was the lack of professional jobs in the area for spouses. Officials also noted, “because the large hospitals offer the latest in technology and research, physicians are often lured to the major cities.”¹⁵

What’s more, a 2009 report showed more than twice the number of doctors per capita in White Plains, NY than in Bakersfield, CA.¹⁶ “Quality of life” issues explained this disparity, according to *Reuters*:

Doctors have been flocking to [the White Plains area] since the 1970s, drawn...[by] quality of life issues that any professional would consider when deciding where to live -- climate, schools, and perhaps most importantly, income....

It’s no mystery why doctors avoid Bakersfield. The summer heat is oppressive, the air quality is poor and the Valley has been pegged by congressional researchers as one of the nation's most depressed regions, on par with the Appalachia region stretching across West Virginia and other coal-mining states.”

Reuters summarized the findings this way: “physicians, the data shows, gravitate towards affluent locales in the United States that already have all the medical help they need.”

If the above studies were not enough to challenge the claims from medical societies about physician supply, the following should remove all doubt. In what could only be described as a grotesque fear-mongering aimed at women by the very doctors who should be caring for them, ACOG released a “map” of New York State, which claimed that there were no obstetricians practicing in seven counties: Cortland, Essex, Hamilton, Lewis, Schoharie, Seneca, and Tioga. In February 2006, CJ&D decided to check ACOG’s facts by making some simple phone calls. Our research showed that six of the seven counties – Cortland, Essex, Lewis, Schoharie, Seneca, and Tioga – either had obstetricians practicing within the county or had obstetrical services available from doctors very nearby. ACOG even *listed* obstetricians practicing in two of these counties on their website at the time. The one remaining county – Hamilton – encompassed one of the most rural parts of the state and had a population of less than 6,000 people – the fewest of any New York County. Based on this, it is debatable whether an obstetrics practice would even be profitable in this county. On the other hand, counties with some of the highest malpractice rates for this specialty, such as Nassau County, Long Island, had the highest number of obstetricians per capita.

In sum, surveys or talking points from medical associations that are conceived by lobbyists or political professionals seeking to demonstrate support for a pre-defined political or legislative agenda – namely capping damages for sick and injured patients – should not be believed.

BEYOND TEXAS AND NEW YORK

Like Black, Hyman, and Silver's work in Texas, there are years of studies showing no correlation between where physicians decide to practice and the malpractice environment, including malpractice insurance rates. Notably, in 1988, California voters passed 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.¹⁷ No other state in the nation has as much protection for doctors against excessive rate hikes and price-gouging by insurers. But even in states without this strong insurance regulatory protection, the evidence clearly shows that that physician supply and the malpractice environment – whether the issue is litigation or insurance - are not linked.

In his 2012 academic study, “The empirical effects of tort reform,” Cornell Law School Professor Theodore Eisenberg, one of the foremost authorities on the use of empirical analysis in legal scholarship,” noted:¹⁸

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.

Other studies have also rejected the notion that there has been any legitimate access problem due to doctors' malpractice insurance problems when they existed.¹⁹ In August 2004, the 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.”²⁰

Other state-specific studies draw the same conclusion. In April 2007, Michelle Mello of the Harvard School of Public Health published a study of physician supply in Pennsylvania in the peer-reviewed journal, *Health Affairs*. The authors,

[L]ooked 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.... What's more, the proportion of high-risk specialists who restricted their practices during the crisis period was not statistically different from the proportion that 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."²¹

Similarly in 2004, the *Cincinnati Enquirer* 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."²²

Even earlier studies have also shown there to be 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."²³ 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."²⁴

The 2003 GAO Report

On August 29, 2003, the U.S. General Accounting Office released a study, requested by three U.S. House Committee Chairs – all Republicans – ostensibly for the purpose of finding support for the American Medical Association's assertions that a widespread health care access "crisis" existed in this country.²⁵ The AMA alleged that these access problems were caused by doctors' medical malpractice insurance rates, that litigation was leading to unnecessary and costly defensive medicine, and that caps on damage awards are the only way to fix these problems.

The GAO found that the AMA was wrong on each point. After receiving a draft of the GAO report, the AMA asked the GAO to "withhold release of the report" and tried to convince GAO to modify its findings.²⁶ Instead, the GAO came back and strongly reaffirmed its findings. Some of these findings are as follows:

- The AMA says that a widespread health care access "crisis" exists as a result of doctors' medical malpractice insurance problems; the GAO found evidence of this to be "inaccurate" and "not substantiated," and that to the extent there are a few access problems, many other explanations can be established "unrelated to malpractice," that problems "did not widely affect access to health care," and/or "involved relatively few physicians."²⁷
 - The GAO studied five so-called "crisis states": Florida, Mississippi, Nevada, Pennsylvania and West Virginia. These states were "among the most visible and often-cited examples of 'crisis' states by the AMA and other provider groups"

and therefore findings with regard to these five states “provides relevant and important insight into the overall problem.”²⁸

- 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, yet the AMA blamed all access problems on medical malpractice litigation. Specifically, the 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.”²⁹
- The GAO “identified reports of provider actions taken in response to medical malpractice pressures—such as reported physician departures and hospital unit closures—that were not substantiated or that did not widely affect access to health care.”³⁰
- “Although some reports have received extensive media coverage, in each of the five states [the GAO] found that actual numbers of physician departures were sometimes inaccurate or involved relatively few physicians.”³¹
- **Florida:**
 - “Reports of physician departures in Florida were anecdotal, not extensive, and in some cases ... inaccurate. For example, state medical society officials told [the GAO] that Collier and Lee counties lost all of their neurosurgeons due to malpractice concerns; however, [the GAO] found at least five neurosurgeons currently practicing in each county as of April 2003.”³²
 - “Provider groups also reported that malpractice pressures have recently made it difficult for Florida to recruit or retain physicians of any type; however, over the past 2 years the number of new medical licenses issued has increased and physicians per capita has remained unchanged.”³³
 - “Hospital association representatives reported that access to newborn delivery services in Florida had been reduced due to the closures of five hospital obstetrics units. However, [the GAO] contacted each of these hospitals and determined that ... demand for [each] now closed obstetrics facility had been low and that nearby facilities provided obstetrics services.”³⁴
- **Mississippi:** “In Mississippi, the reported physician departures attributed to recent malpractice pressures were scattered throughout the state and represented 1 percent of all physicians licensed in the state. Moreover, the number of physicians per capita has remained essentially unchanged since 1997.”³⁵
- **Nevada:** “In Nevada, 34 OB/GYNs reported leaving, closing practices, or retiring due to malpractice concerns; however, confirmatory surveys conducted by the Nevada State

Board of Medical Examiners found nearly one-third of these reports were inaccurate—8 were still practicing and 3 stopped practicing due to reasons other than malpractice. Random calls [the GAO] made to 30 OB/GYN practices in Clark County found that 28 were accepting new patients with wait-times for an appointment of 3 weeks or less. Similarly, of the 11 surgeons reported to have moved or discontinued practicing, the board found 4 were still practicing.”

- **Pennsylvania:** “In Pennsylvania, despite reports of physician departures, the number of physicians per capita in the state has increased slightly during the past 6 years.... Departures of orthopedic surgeons comprise the largest single reported loss of specialists in Pennsylvania. Despite these reported departures, the rate of orthopedic surgeries among Medicare enrollees in Pennsylvania has increased steadily for the last 5 years, as it has nationally.”³⁶
- **West Virginia:** “In West Virginia, although access problems reportedly developed because two hospital obstetrics units closed due to malpractice pressures, officials at both of these hospitals told [the GAO] that a variety of factors, including low service volume and physician departures unrelated to malpractice, contributed to the decisions to close these units. One of the hospitals has recently reopened its obstetrics unit.... In West Virginia, . . . the number of physicians per capita increased slightly between 1997 and 2002.”³⁷

THE REAL FACTORS: LIFESTYLE, OPPORTUNITY AND DEMAND

In their study of Texas’ physician supply, professors Black, Hyman, and Silver speculate that one possible reason for the ongoing doctor shortage in Texas “could be related to the number of Texans who lack health insurance [since] demand for medical services from insured patients is a strong lure for physicians.”³⁸ Currently, Texas ranks “dead last in the percent of individuals with health insurance and are near the bottom in the percent of workers with employer-based health insurance.”³⁹ Black, Hyman, and Silver add, “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.”⁴⁰ Indeed, as pointed out earlier in the discussion of New York, physician shortages also correlate to stagnating local economies and decreasing populations in those regions, not to lawsuits or insurance rates.

The argument is also sometimes made that the malpractice environment drives doctors out of certain high-risk specialties. But as with choice of location, lifestyle considerations are also among the most important factors for determining a physician’s choice of specialty. As reported in the *New York Times*, “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.”⁴¹ 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.’”

CONCLUSION

Over two decades of U.S. health care data show laws restricting patients’ rights have no measurable effect on physician supply. Any notion that repealing or increasing MICRA’s cap will drive doctors out of California or make it less likely they will practice in certain areas is, sadly, little more than unsubstantiated fear-mongering by medical lobbies.

NOTES

¹ Suzanne Batchelor, “Baby, I Lied.” *Texas Observer*, October 19, 2007. <http://www.texasobserver.org/2607-baby-i-lied-rural-texas-is-still-waiting-for-the-doctors-tort-reform-was-supposed-to-deliver/>.

² Dave Montgomery, “Texas Senate passes bill to address state’s doctor shortage,” *Star-Telegram*, April 17, 2013.

³ Bernard Black, David Hyman, Charles Silver, “Black, Silver, Hyman: Tort reform not the tonic it’s touted to be,” *Austin American Statesman*, April 9, 2013. <http://www.statesman.com/news/news/opinion/black-silver-hyman-tort-reform-not-the-tonic-its-t/nXG9J/>

⁴ David A. Hyman et al., “Does Tort Reform Affect Physician Supply? Evidence from Texas,” Northwestern University Law School, Law and Economics Research Paper No. 12-11; University of Illinois, Program in Law, Behavior and Social Science Research Paper No. LE12-12; University of Texas Law School, Law and Economics Research Paper No. 225 (June 2012) at 8, <http://ssrn.com/abstract=2047433>.

⁵ See, Manhattan Institute’s Ted Frank, “Post-tort-reform Texas doctor supply,” *PointofLaw.com*, May 4, 2012, <http://www.pointoflaw.com/archives/2012/05/post-tort-reform-texas-doctor-supply.php> (“I, for one, am going to stop claiming that Texas tort reform increased doctor supply without better data demonstrating that.”)

⁶ David A. Hyman et al., “Does Tort Reform Affect Physician Supply? Evidence from Texas,” Northwestern University Law School, Law and Economics Research Paper No. 12-11; University of Illinois, Program in Law, Behavior and Social Science Research Paper No. LE12-12; University of Texas Law School, Law and Economics Research Paper No. 225 (June 2012) at 14, <http://ssrn.com/abstract=2047433>.

⁷ *Id.* at 3.

⁸ *Id.* at 19.

⁹ *Id.* at 21.

¹⁰ *Id.* at 14.

¹¹ *Id.* at 25.

¹² Armstrong DP and Forte GJ. *Annual New York Physician Workforce Profile, 2006 and 2007 Editions*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany.

¹³ Changing Practice Patterns of Obstetricians/Gynecologists in New York, April 2006. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany.

¹⁴ Resident Exit Survey Summary Brief: *Why Do New Physicians Leave New York and How Do They Find Their Jobs?* David P. Armstrong, Gaetano J. Forte, and Jean Moore, Center for Health Workforce Studies, School of Public Health University at Albany, State University of New York, December 2007.

¹⁵ Carol Thompson, “Recruiting and Retaining Physicians Not an Easy Task,” *Oswego County Business*, April/May 1998.

¹⁶ Chris Baltimore, “SPECIAL REPORT: Are doctors what ails healthcare?” *Reuters*, Nov. 6, 2009, found at <http://www.reuters.com/article/companyNews/idUKTRE5A524720091106?pageNumber=1&virtualBrandChannel=11564>

¹⁷ In the twelve years after Prop. 103 (1988-2000), malpractice premiums dropped 8 percent in California, while nationally they were up 25 percent. Consumer Watchdog, *Insurance Regulation, Not Malpractice Caps, Stabilize Doctors' Premiums* (January 2003), <http://www.consumerwatchdog.org/node/7790>. 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,¹⁷ saving doctors \$66 million. Consumer Watchdog, “California Group Successfully Challenges 29.2% Rate Hike Proposed by California’s Ninth Largest Medical Malpractice Insurer; Proposition 103 Invoked to Slash Medical Protective Company’s Requested Increase by 60%,” September 16, 2004, <http://www.consumerwatchdog.org/newsrelease/california-group-successfully-challenges-292-rate-hike-proposed-californias-ninth-largest>. Moreover, Prop. 103 has allowed the state Insurance Commissioner to take action and lower excessive insurance rates for doctors. See October 2012 news release issued by the California Department of Insurance. California Department of Insurance, “Insurance Commissioner Dave Jones Announces Second Medical Malpractice Rate Reduction for NORCAL Mutual,” October 2, 2012, <http://insurancenewsnet.com/article.aspx?id=359412#.UG2TCRjBpJW>. (“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.”)

¹⁸ Theodore Eisenberg, “The Empirical Effects of Tort Reform,” April 1, 2012. *Research Handbook on the Economics of Torts*, forthcoming, found at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2032740.

¹⁹ Since 2006, the nation has been in a “soft” insurance market, with rates stable and dropping in every state whether or not “tort reforms” or “cap” have been enacted.

²⁰ Katherine Baicker and Amitabh Chandra, “The Effect of Malpractice Liability on the Delivery of Health Care,” *NBER Working Paper Series* (August 2004), found at <http://www.dartmouth.edu/~kbaicker/BaickerChandraMedMal.pdf>.

²¹ “Malpractice Premium Spike In Pennsylvania Did Not Decrease Physician Supply,” *Health Affairs*, April 24, 2007, found at <http://www.healthaffairs.org/press/marapr0707.htm>.

²² Tim Benfield, “Region Gains Doctors Despite Malpractice Bills,” *Cincinnati Enquirer*, October 11, 2004.

²³ Eleanor D. Kinney, “Malpractice Reform in the 1990s, Past Disappointment, Future Success?” 20 *J. Health Pol. Pol’y & L.* 99, 120 (1996), cited in Marc Galanter, “Real World Torts,” 55 *Maryland L. Rev.* 1093, 1152 (1996).

²⁴ Eleanor D. Kinney & William P. Gronfein, “Indiana’s Malpractice System: No-Fault by Accident,” 54 *Law & Contemp. Probs.* 169, 188 (1991), cited in Marc Galanter, “Real World Torts,” 55 *Maryland L. Rev.* 1093, 1152-1153 (1996).

²⁵ *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, General Accounting Office, GAO-03-836, Released August 29, 2003, <http://www.gao.gov/new.items/d03836.pdf>

²⁶ *Id.* at 38.

²⁷ *Id.* at 12-24.

²⁸ *Id.* at 38.

²⁹ *Id.* at 13.

³⁰ *Id.* at 16.

³¹ *Id.* at 17.

³² *Ibid.*

³³ *Id.* at 17-18.

³⁴ *Id.* at 16.

³⁵ *Id.* at 18.

³⁶ *Ibid.*

³⁷ *Id.* at 16, 17, 19.

³⁸ Bernard Black, David Hyman, Charles Silver, “Black, Silver, Hyman: Tort reform not the tonic it’s touted to be,” *Austin American Statesman*, April 9, 2013. <http://www.statesman.com/news/news/opinion/black-silver-hyman-tort-reform-not-the-tonic-its-t/nXG9J/>

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⁴⁰ David A. Hyman et al., “Does Tort Reform Affect Physician Supply? Evidence from Texas,” Northwestern University Law School, Law and Economics Research Paper No. 12-11; University of Illinois, Program in Law, Behavior and Social Science Research Paper No. LE12-12; University of Texas Law School, Law and Economics Research Paper No. 225 (June 2012) at 8, <http://ssrn.com/abstract=2047433>.

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