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October 4, 2007

Richard F. Daines, M.D., Commissioner
Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237

Eric R. Dinallo, Superintendent
State Of New York
Insurance Department
One Commence Plaza
Albany, New York 12257

Dear Commissioner Daines and Superintendent Dinallo:

The following information is submitted to the medical malpractice task force in answer to several questions raised in the workplan for October 15, 2007.

First, the notion that either the insurance or medical liability system is driving doctors out of New York or out of their specialty has been one of most sensationalized fictions about the medical liability system today. That is why, when exploring a topic like this, it is important to distinguish between unbiased academic or government studies, and "push polls" or surveys from medical associations that are conceived by lobbyists or political professionals seeking to demonstrate support for a pre-defined political or legislative agenda.

As a national consumer organization that has, for years, been fighting the insurance and medical lobbies over patients' legal rights, we know exactly how issues of "access" tend to be discussed – couched in fear-mongering, not facts; anecdotes, not academic studies. We hope the task force rejects this approach. If the medical groups would like to discuss anecdotes or biased surveys of members, we can certainly point the task force to thousands and thousands of other kinds of stories - individuals cases of medical negligence. These injured patients are often the forgotten faces in the debate over medical malpractice. Unfortunately, they are not represented on this task force. I hope that at some point, this task force decides to hear from them.

But given that this is unlikely, we urge this task force to firmly reject information from medical groups about access that is grounded in anecdotes, biased surveys and fear. I am sure many victims of medical negligence around New York State would be more than happy to respond to them in person at upcoming task force meetings. Each will tell you that they had access to medical care – their access was to inept physicians and dangerous hospitals. If given the choice, each would have gladly given up convenience for competence.

NEW YORK AND THE COUNTRY

In October 2004, the Center for Justice & Democracy endorsed a study by NYPIRG, Center for Medical Consumers and Public Citizen entitled, *The Doctor* Is *In: New York's Increasing Number of Doctors*. This report is attached. The study answers a number of questions raised by the task force, including issues surrounding New York State physician supply, which is plentiful and increasing, as well as how demographic shifts and other factors have impacted the choice of specialty and location, discussed later in this paper. Some of the report's key physician supply findings are 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.

THE "ACCESS" CON, NATIONALLY

On August 29, 2003, the U.S. General Accounting Office released *Medical Malpractice: Implications of Rising Premiums on Access to Health Care* (GAO-03-836).[1] The study, requested by three U.S. House Committee Chairs – all Republicans – was commissioned ostensibly to find support for the AMA's assertions that a widespread health care access "crisis" existed in this country caused by doctors' medical malpractice insurance problems, that litigation was leading to unnecessary and costly defensive medicine, and that caps on damage awards are the only way to fix these problems and reduce doctors' insurance premiums.

The GAO found that the AMA was wrong on each point.

Most importantly, the GAO found that the AMA and doctors groups had based their claims on information GAO determined 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." Moreover, GAO found evidence that the AMA and state medical societies, and the member doctors who purposely walked out on their patients in some states, had themselves manufactured a health care access problem as part of their political campaign to pressure lawmakers into severely limiting injured patients' rights.

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. (p. 38). 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; 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." (pp.12-24):**
    - 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." (p. 38) **(Note: These states all had significantly more serious insurance problems than New York).**
    - 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, 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." (p. 13).

[1] *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

  - 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." (p. 16).
  - "Although some reports have received extensive media coverage, in each of the five states [GAO] found that actual numbers of physician departures were sometimes inaccurate or involved relatively few physicians." (p. 17)
- **Florida:**
  - "Reports of physician departures in Florida were anecdotal, not extensive, and in some cases … inaccurate. For example, state medical society officials told [GAO] that Collier and Lee counties lost all of their neurosurgeons due to malpractice concerns; however, [GAO] found at least five neurosurgeons currently practicing in each county as of April 2003."(p. 17)
  - "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." (p. 17-18)
  - "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, [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." (p. 16)
- **Florida/Pennsylvania:** "Contrary to reports of reductions in mammograms in Florida and Pennsylvania, … utilization of these services among Medicare beneficiaries is higher than the national average in both Florida, where utilization rates have recently increased, and in Pennsylvania. . . . [T]he longer wait times cited by provider organizations were more likely due to causes other than malpractice pressures." (p. 21)
- **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." (p. 18)
- **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 [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." (p. 18)
- **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." (p. 18)

- **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 [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." (p.16-17). "In West Virginia, . . . the number of physicians per capita increased slightly between 1997 and 2002." (p. 19).

Further, GAO found that the AMA's National Physician Survey on Professional Medical Liability (April 2003), and other physician "surveys" upon which AMA based its claims that physicians are limiting their practices, were unreliable due to a low response rate that "precludes the ability to reliably generalize the survey results to all physicians." GAO also harshly criticized evidence continuously cited by the AMA that the tort system encouraged unnecessary defensive medicine, finding this evidence unreliable. (p. 26-27)

The GAO is not alone. Other studies have rejected the notion that there has been any legitimate access problem due to doctors' malpractice insurance problems. 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."[2]

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 "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.… 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."[3]

Similarly, 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

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[2] http://www.dartmouth.edu/~kbaicker/BaickerChandraMedMal.pdf

[3] "Malpractice Premium Spike In Pennsylvania Did Not Decrease Physician Supply; Contrary To Survey Responses, The Number Of Physicians In "High-Risk" Specialties In Pennsylvania Who Restricted Or Left Their Practices Did Not Increase During Malpractice "Crisis", *Health Affairs,* April 24, 2007; http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.3.w425.

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."[4]

Past 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."[5] 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."[6]

HISTORY OF EXPLOITING OB/GYNS AND OTHERS IN NEW YORK STATE

As if the above studies were not enough to give the task force reason to doubt information or "surveys" about doctors leaving New York State, recent reports from the American College of Obstetricians and Gynecologists (ACOG) should remove all doubt. In what could only be described as a grotesque exploitation of women and children by the very doctors who should be caring for them, ACOG has released reports ostensibly showing an exodus of doctors from a number of states due to lawsuits by sick and injured women and children, and arguing that their compensation should be capped. Incredibly, this list has included New York State since at least 2002. That year, New York State had the fourth highest per capita number of OB/GYNs in the nation.[7]

ACOG later 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, the Center for Justice & Democracy decided to check ACOG's facts by conducting the same kind of "fact check" of ACOG that the General Accounting Office did in 2003, discussed earlier. Our research is attached. It shows 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 nearby. Even ACOG 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, had the highest number of obstetricians per capita.

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[4] Tim Bonfield, "Region Gains Doctors Despite Malpractice Bills," *Cincinnati Enquirer*, October 11, 2004.
[5] 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).
[6] Kinney & 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).
[7] See, NYPIRG, Center for Medical Consumers and Public Citizen, *The Doctor* Is *In: New York's Increasing Number of Doctors*, October 2004.

Underserved areas and certain specialties are suffering because of lifestyle factors, not income and expense considerations. Long before insurance rates started rising again in New York State, 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."[8]

It is now well-documented that lifestyle considerations are the most important factor for determining not only a doctor's choice of location, but also his or her choice of specialty - far more important than income and expenses. 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."[9] 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.'"

Another key factor is age. As reported in *The Doctor* Is *In*,

> 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 study 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."[10]

LIABILITY AFFECTS TREATMENT AND CARE – BY IMPROVING IT

In a March 5, 1995 *New York Times* article, Dr. Wayne Cohen, then-medical director of the Bronx Municipal Hospital, said, "The city was spending so much money defending obstetrics

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[8] Carol Thompson, "Recruiting and Retaining Physicians Not an Easy Task," *Oswego County Business,* April/May 1998.

[9] Matt Richtel, "Young Doctors and Wish Lists: No Weekend Calls, No Beepers, *New York Times,* January 7, 2004.

[10] NYPIRG, Center for Medical Consumers and Public Citizen, *The Doctor* Is *In: New York's Increasing Number of Doctors*, October 2004 at 20, citing Grumbach, et al. Charges for Obstetric Liability Insurance and Discontinuation of Obstetric Practice in New York, *The Journal of Family Practice,* Vol. 44, No. 1 (Jan. 1997) at 61.

suits, they just made a decision that it would be cheaper to hire people who knew what they were doing."[11]

This sentiment continues to ring true. On May 11, 2006, the *New England Journal of Medicine* published a breakthrough article arguing that litigation against hospitals improves the quality of care for patients.[12] Highlights of this article include:

- "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."
- "The major safety-related reasons for which hospitals have been successfully sued are inadequate nursing staff and inadequate facilities." For example, the Illinois Supreme Court found that a hospital was at fault for failing to provide enough qualified nurses "to monitor a patient, whose leg had to be amputated because his cast had been put on too tight."
- In a 1991 Pennsylvania Supreme Court case, the court listed four areas from which hospital safety obligations should flow: "the maintenance of safe and adequate facilities and equipment, the selection and retention of competent physicians, the oversight of medical practice within the hospital, and the adoption and enforcement of adequate rules and policies to ensure the quality of care for patients."
- 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."
- "[B]y working with patients (and their lawyers) to establish a patient's right to safety, and by proposing and supporting patient-safety initiatives, physicians can help pressure hospitals to change their operating systems to provide a safer environment for the benefit of all patients."

By the same token, history shows that removing the threat of litigation can hurt patients. The Virginia Birth-Related Neurological Injury Compensation Program, which forces most birth-injury cases into an administrative system, has hurt patients and, some birth injury experts fear, has allowed the state to become a safe harbor for negligent and reckless doctors who should not be practicing medicine at all, according to series of investigations in the *Richmond Dispatch*.[13]

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[11] Dean Baquet and Jane Fritsch, "New York's Public Hospitals Fail, and Babies Are the Victims," *New York Times,* March 5, 1995.

[12] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.

[13] Bill McKelway, "Danville Has High Birth-Injury Rate; Critics Say Virginia Law Shields Doctors from Lawsuits," *News Virginian*, June 1, 2003; McKelway, "Brain Injuries Spur No Action; Case Review, Required by Law, Is Not Being Done, Va. Study Found," *Richmond Times Dispatch*, Jan. 14, 2003; McKelway, "Brain-Injury Program's Outlook Dim; Cost Savings for Doctors Meant Less for Children," *Richmond Times Dispatch*, Nov. 16, 2002; Liz Szabo & Elizabeth Simpson, "Birth Injuries Get 'Minimal Review; State Report Says Board Must Hold Doctors Accountable," *Virginian-Pilot*, Nov. 15, 2002; McKelway, "Study Faults Program for Brain-Injured; Shortcomings Found in Care for Children," *Richmond Times Dispatch*, Nov. 13, 2002.

Unfortunately, New York State's current "tort reform" laws could actually endanger patients. In the mid-1980s, New York enacted severe medical malpractice "tort reforms."[14] There is now evidence presented, ironically, by one of the most active and partisan pro-"tort reform" groups around - the American Enterprise Institute - that one of these, repealing the collateral source rule, may endanger infant safety.

The collateral source rule's premise is that the wrongdoer's liability and obligation to compensate should be measured by the harm done and the extent of the injuries inflicted. In this way, the rule helps promote deterrence of unsafe conduct. New York has "reformed" (i.e. repealed) this rule. A recent paper presented by the Associate Director of the American Enterprise Institute's Liability Project found that:

> [C]ollateral source reform leads to a statistically significant increase in infant mortality.... For whites, the increase is estimated to be between 10.3 and 14.6 additional deaths per 100,000 births. This represents an increase of about 3 percent. For blacks, the collateral source reversal leads to between 47.6 and 72.6 additional deaths per 100,000 births, a percentage increase between 5 and 8 percent. These results suggest that the level of care provided decreases with the passage of collateral source reform.…The relationships we estimate between reform measures and infant mortality rates appear to be causal.... In summary, these results show that collateral source reform leads to increased infant mortality."[15]

FEAR OF LITIGATION IS NOT THE REASON DOCTORS DO NOT REPORT ERRORS OR COMMUNICATE WITH THEIR PATIENTS.

In its May 11, 2006 article, the *New England Journal of Medicine* noted that only one quarter of doctors disclosed errors to their patients, but "the result was not that much different in New Zealand, a country that has had no-fault malpractice insurance" [i.e., no litigation against doctors] for decades. In other words, "There 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."[16] Other studies have produced similar results.

For example, according to a recent study by Dr. Thomas Gallagher, a University of Washington internal-medicine physician and co-author of two studies published in the *Archives of Internal*

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[14] The American Tort Reform Association's "medical liability reform" platform consists of 4 items: (1) a $250,000 limit on noneconomic damages; (2) a sliding scale for attorney's contingent fees; (3) periodic payment of future damages; and (4) abolition of the collateral source. New York State has already enacted items 2, 3 and 4, giving the state the distinction of having some of the harshest tort restrictions of any state in the country, and providing doctors and hospitals with more liability protections than nearly any other profession or industry in the state.

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

[16] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.

Medicine, "Comparisons of how Canadian and U.S. doctors disclose mistakes point to a 'culture of medicine,' not lawyers, for their behavior." [17] 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… yet "doctors are just as reluctant to fess up to mistakes." Moreover, "doctors' thoughts on how likely they were to be sued didn't affect their decisions to disclose errors." The authors believe "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."[18]

When fear of litigation is removed, the "culture of secrecy" within the medical profession still exists. In Massachusetts, for example, where nearly all hospitals fall under the state's charitable immunity laws that cap their liability at $20,000, hospitals are still "vastly underreporting their mistakes to regulators and the public." According to *Boston Magazine,* "The biggest challenge is finding a way to break the culture of silence in hospital corridors that has long crippled efforts to cut medical errors, just as the blue wall of silence has stifled police investigations.[19]

THE DEFENSIVE MEDICINE MYTH

As noted in the 2003 General Accounting Office, above, in our September 17, 2007 task force letter, studies consistently find no reliable support for the allegation that physicians engage in widespread and costly "defensive medicine."

The General Accounting Office, noting everything from low response rates to surveys (10 and 15 percent) and the general failure of surveys to indicate whether physicians engaged in "defensive behaviors on a daily basis or only rarely, or whether they practice them with every patient or only with certain types of patients," the GAO found both AMA and American Academy of Orthopedic Surgeons surveys on defensive medicine highly unreliable. [20] Moreover, GAO noted,

> "Officials from AMA and several medical, hospital, and nursing home associations in the nine states we reviewed told us that defensive medicine exists to some degree, but that it is difficult to measure; and officials cited surveys and published research but could not provide additional data demonstrating the extent and costs associated with defensive medicine. **Some officials pointed out that factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures.** For example, a Montana hospital association official said that revenue-enhancing motives can encourage the utilization of certain types of diagnostic tests, while officials from Minnesota and California medical associations identified managed care as a factor that can mitigate defensive practices. **According to some research, managed care provides**

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[17] Carol M. Ostrom, "Lawsuit fears aren't reason for docs' silence, studies say," *Seattle Times*, August 17, 2006 , citing from Thomas Gallagher, M.D., et al, "Choosing your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients," *Archives of Internal Medicine,* Aug. 14, 2006.

[18] *Ibid.*

[19] Doug Most, "The Silent Treatment," *Boston Magazine* (Feb. 2003).

[20] *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 at 26-27.

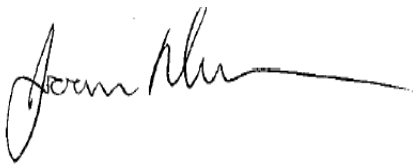
a financial incentive not to offer treatments that are unlikely to have medical benefit."

Even before the widespread onset of managed care in this country, the congressional Office of Technology Assessment (OTA) found that less than 8 percent of all diagnostic procedures were likely to be caused primarily by liability concerns. OTA found that 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."[21]

According to a Congressional Budget Office study, "some so-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by the positive (albeit small) benefits to patients.... CBO believes that savings from reducing defensive medicine would be very small." CBO also found that limiting tort liability would have no significant impact on health care spending.[22]

Please do not hesitate to contact us with any questions.

Very sincerely,



Joanne Doroshow
Executive Director

Attachments

[21] U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H--6O2 (1994).
[22] Congressional Budget Office, *Limiting Tort Liability for Medical Malpractice* 1, 6 (Jan. 8, 2004).