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February 7, 2013

John Podesta, Chair
Neera Tanden, President
Center for American Progress
1333 H Street, NW, 10th Floor
Washington, DC 20005

Dear Mr. Podesta and Ms. Tanden:

Attached please find extensive comments concerning one section of your Senior Protection Plan (SPP) entitled "Reduce the costs of defensive medicine."

We recently met with Maura Calsyn, Associate Director of Health Policy at American Progress, about this aspect of the SPP. While we appreciated the meeting, Ms. Calsyn indicated that she was not involved in drafting this section. According to the SPP document, this idea "originally appeared in Ezekiel Emanuel and others, 'A Systemic Approach to Containing Health Care Spending.'" The relevant CAP proposal recommends providing a "safe harbor" to physicians, which is described as follows:

> Physicians would be presumed to have no liability if they:
>
> - Document adherence to evidence-based clinical practice guidelines
> - Use qualified health information technology systems
> - Use clinical decision support systems that incorporate guidelines

CAP also attaches a $5 billion "savings" figure to this idea (without presenting substantiation, we might add), although we have heard Dr. Emanuel say that this proposal will not save much money but is more about "changing the psychology of doctors." We would like to address both the proposal and the introductory paragraphs describing the problem as CAP sees it.

Our organization has worked on civil justice issues specifically as they relate to medical malpractice since its founding in 1998. I have personally been involved since the late 1980s. As you may know, the general topic of medical malpractice has been politically heated since the first liability insurance crisis of 1975, when political solutions immediately focused not on the insurance industry's role creating problems for doctors, but rather on weakening patients' legal rights. We have worked with many families and individual patients who have traveled to Washington, DC and state capitols to oppose so-called "tort reform" laws. For their trouble, I have personally witnessed victims being heckled and insulted by doctors to their face. It is not

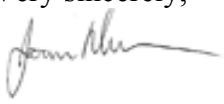
easy for patients who have lost a leg, their eyesight or a child to continue hearing from medical lobbies that they – victims who file claims – are the problem, as opposed to the medical negligence that caused these tragedies.

By no means are we suggesting that CAP and Dr. Emanuel share this kind of hostility. We know that you are genuinely concerned about patients, doctors and health care costs. However, we strongly believe that this proposal, as described above, is incredibly misguided. It will accomplish none of CAP's goals but instead feed into the same narrative that continues to victimize patients who have been injured.

Unlike the rest of the SPP, which deals with issues more specific to the provider community, this section deals with changing legal rules in medical malpractice cases, crossing over into an entirely different branch of government – the courts. We believe CAP made a mistake in not sitting down with experienced plaintiff or consumer representatives and working toward recommendations that would accomplish the goals we all have: reducing deaths, injuries, claims and lawsuits. Given how much we already know about how to improve patient safety today, which is a massive and complex problem, the last thing we should do is try to solve it by increasing the obstacles sick and injured patients face in the already difficult process of prevailing in court.

History has shown that when both sides try to work together to come up with solutions that each side finds appropriate, the outcome is much better for doctors and patients. We hope CAP will reconsider doing that, and we would be happy to help make it happen. Please do not hesitate to contact us with any questions.

Very sincerely,



Joanne Doroshow
Executive Director

cc:
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CRITIQUE OF CENTER FOR AMERICAN PROGRESS, "REDUCE THE COSTS OF DEFENSIVE MEDICINE," *SENIOR PROTECTION PLAN* (SPP), NOVEMBER 2012

Joanne Doroshow, Executive Director
Center for Justice & Democracy at New York Law School
February 7, 2013

The relevant proposal in the SPP section titled "Reduce the costs of defensive medicine" recommends providing a "safe harbor" to physicians, which is described as follows:

> Physicians would be presumed to have no liability if they:
>
> - Document adherence to evidence-based clinical practice guidelines
> - Use qualified health information technology systems
> - Use clinical decision support systems that incorporate guidelines

FOCUSING ON THE WRONG VICTIM

The idea behind this section is reflected in its first paragraph:

> More than 75 percent of physicians—and virtually all physicians in high-risk specialties—face a malpractice claim over the course of their career. While most claims do not result in liability, the risk of being sued may cause physicians to practice defensive medicine. Litigation costs are higher for claims that result in awards, but litigation costs for claims that do not result in awards are still significant (averaging $17,130).

Before challenging the specific statistics mentioned, it is important to first discuss the general focus. For over 30 years, policy proposals in the area of medical malpractice have concentrated almost entirely on the "doctors as victims" narrative. In other words, the insurance and medical lobbies effectively turned the malpractice issue on its head, so that policymakers treat medical malpractice primarily as if doctors and their insurers were the victims of it, instead of the

hundreds of thousand of patients who wind up dead or injured each year. This is well-reflected in the hundreds of medical malpractice laws that have passed around the country, virtually all of which are designed to weaken the liability of health care providers. With few exceptions, these laws apply to cases no matter how much merit they have, the extent of the misconduct of the provider or the severity of an injury. Some laws have had devastating consequences for injured patients, as this recent *Texas Tribune* story illustrates.[1] We are glad CAP is not endorsing the types of severe proposals that have been enacted in Texas, but we are extremely disappointed that CAP is continuing to address medical malpractice as a "doctors are victims" issue.[2]

The health care industry already benefits from more liability protections than virtually any other industry or profession in the nation. The vast majority of preventable errors that physicians commit never result in a claim at all. (Even Dr. Pauline Chen puts this likelihood at less than 5% in her recent *New York Times* article about the "drawn out lawsuit process."[3]) And when they do result in a lawsuit, physicians have experienced, well-paid defense attorneys representing them. Moreover, these cases are not frivolous. Even the General Counsel for the American Tort Reform Association has said, "It is 'rare or unusual' for a plaintiff lawyer to bring a frivolous malpractice suit because they are too expensive to bring."[4] And in a recent Sunday *Boston Globe Magazine* article, Dr. Darshak Sanghavi, the chief of pediatric cardiology at the University of Massachusetts Medical School, wrote, "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."[5]

But as if none of that were true, policy solutions are still dictated by physicians who, in the words of Dr. Sanghavi, "bemoan how they're often victims of frivolous lawsuits …." Recommendations, including CAP's, continue to focus on limiting the liability of doctors while the official policy justifications keep shifting.[6] It seems only when a physician has an experience

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[1] Becca Aaronson, "Despite Counsel, Amputee Hindered by Tort Laws," *Texas Tribune*, January 25, 2013, http://www.texastribune.org/2013/01/25/double-amputee-challenges-texas-tort-reform/.

[2] We understand that there is also a "patient safety" goal with CAP's proposal but, as will be explained later, trying to tackle the nation's epidemic of medical errors with this kind of proposal is not only improper but could also be counterproductive.

[3] Pauline W. Chen, M.D. "The Drawn Out Process of the Medical Lawsuit," *New York Times*, January 24, 2013, http://well.blogs.nytimes.com/2013/01/24/the-drawn-out-process-of-the-medical-lawsuit/.

[4] Mark A. Hofmann, "White House open to medical liability changes," *Business Insurance*, January 30, 2011, http://www.businessinsurance.com/article/20110130/ISSUE01/301309974.

[5] Darshak Sanghavi, M.D., "Medical malpractice: Why is it so hard for doctors to apologize?" *Boston Globe Magazine,* January 27, 2013, http://www.bostonglobe.com/magazine/2013/01/27/medical-malpractice-why-hard-for-doctors-apologize/c65KIUZraXekMZ8SHlMsQM/story.html.

[6] Justifications for "tort reforms" tend to change depending upon which part of the property/casualty insurance industry's economic cycle the nation is in. The industry's economic cycle leads to what are known as "hard" and "soft" insurance markets. There have been three full cycles in the past 35 years, with soft markets characterized by stable or low rates and hard markets characterized by sudden and astronomical rate hikes for policyholders – in this case, doctors. These hard markets can lead to devastating "liability insurance crises" and, historically, the only policy proposals that have worked to prevent or bring down excessive price hikes are insurance regulation. Unfortunately, medical lobbies neither support stronger insurance laws nor join consumer groups in what have been a few very successful efforts to challenge doctors' excessive rates during hard markets, probably because obtaining medical malpractice liability limits is the more critical goal for the medical profession. Eventually, rates stabilize nationwide on their own for reasons having nothing to do with tort law restrictions enacted in particular states. This period is called the "soft market." The property/casualty industry, including the medical malpractice line, has been

like that of Dr. Lora Ellenson that we ever hear a different or remorseful perspective from a doctor. Dr. Ellenson is a pathologist at NY Presbyterian Hospital-Weill Cornell Medical Center. Her son, Thomas, was brain-damaged from a birth injury due to negligence. In 2011, she told the *New York Daily News*[7]:

> My son cannot walk or talk.…He is not able to carry out activities of daily living – eating, dressing, toileting, bathing – without constant assistance from an adult. He also needs a motorized wheelchair, a speech output device and a wheelchair-accessible van, just to name a few.…
>
> As a physician, I have also had to grapple with the implications for my profession. I have had to come face-to-face with the knowledge that mistakes are made.
>
> Like most physicians, I live with the reality that we might one day make an error and be sued. When that day comes, I will be grief-stricken, not because of the process – although I am sure that won't be pleasant – but due to the fact that I may have caused someone irreparable damage.

As Dr. Ellenson notes, the experience of being sued is not pleasant. We understand that. We know that she would have done anything to have made her lawsuit unnecessary. However, sometimes they are necessary. And given the carnage created by the number of preventable medical errors that occur every day,[8] lawsuits are relatively rare, and the statistics cited by CAP are very misleading. They are not unlike the information discussed in an article in the September 2010 edition of *Health Affairs* titled "Physicians' Fears Of Malpractice Lawsuits Are Not Assuaged By Tort Reforms," by David Katz, M.D., Associate Professor of Medicine with University of Iowa Health Care, and several other authors. They found that doctors' fear of lawsuits is "out of proportion to the actual risk of being sued" and enacting "tort reforms" has no impact on this phenomenon. 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 more and more liability limits for doctors.

Misleading Statistics

As to the statistics themselves, a cursory review of data sources for the statement that "More than 75 percent of physicians—and virtually all physicians in high-risk specialties—face a

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in a soft market period since 2006 and incredibly profitable. For more, *see* Americans for Insurance Reform, *Repeat Offenders; How The Insurance Industry Manufactures Crises And Harms America* (2012), http://centerjd.org/content/study-repeat-offenders-how-insurance-industry-manufactures-crises-and-harms-america; Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care* (2009), http://www.insurance-reform.org/studies/TrueRiskF.pdf; Tom Baker, *The Medical Malpractice Myth*. Chicago: University of Chicago Press (2005). During soft market periods and without spiking insurance rates to justify their continuing push for more liability limits, new arguments tend to surface. The "defensive medicine" argument appears to fit within that political construct.

[7] Denis Hamill, "Doctor with disabled son is no fan of governor's plan to cap malpractice suits," *New York Daily News*, March 13, 2011, http://www.nydailynews.com/new-york/doctor-disabled-son-fan-governor-plan-cap-malpractice-suits-article-1.123846.

[8] *See infra*, Section on Patient Safety.

malpractice claim over the course of their career" suggest good reason to question them. They originated in two articles (and now appear in a third[9]) from a basic data set supplied to RAND's Institute for Civil Justice (ICJ) from one insurance company, whose business is mostly in one state, California. None of this raw data was publicly disclosed.[10] According to a *Forbes* article this week,[11] it appears that The Doctors' Company is that insurance company. It was not identified by name in any of these articles. The company's chairman and CEO, Dr. Richard E. Anderson, sits on the ICJ Board of Overseers.[12] This creates a clear conflict of interest with ICJ's staff researchers, or at least the perception of a conflict.

Dr. Anderson is one of the most outspoken insurance executives in the nation advocating "tort reform." For years, The Doctors Company held "tort reform" summits with the U.S. Chamber of Commerce, sometimes also with the American Tort Reform Association and the National Association of Manufacturers.[13] More recent summits were "hosted at the offices of the U.S. Chamber Institute for Legal Reform."[14] Their main purpose, in addition to "honoring" people, was to "explore new ideas and strategies" for passing tort reform. The company regularly lobbies for such laws, and Dr. Anderson is often quoted in the media praising efforts to strip patients of their legal rights.[15] In the recent *Forbes* article, Dr. Anderson repeated myths about "frivolous lawsuits" and stated, "Possible solutions to this crisis…include tort reform, and caps for non-economic damages (pain and suffering), which many states have already enacted."[16]

It is through this tainted prism that everything – from the design of the research behind these statistics, to how the "problem" is described in the published articles, to the "tort reform" ideas discussed – must be viewed. For example, the numbers were reached using "multivariate regression" based on the physician's age, specialty and a few other factors. Yet the most obvious consideration, namely a physician's actual malpractice history, including whether there were multiple claims against the same physician, was apparently considered irrelevant. It was not

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[9] Seth A. Seabury et al., "On Average, Physicians Spend Nearly 11 Percent Of Their 40-Year Careers With An Open, Unresolved Malpractice Claim," 32 *Health Aff* 111 (January 2013), http://content.healthaffairs.org/content/32/1/111?related-urls=yes&legid=healthaff;32/1/111.

[10] Insurance data can always be questioned, which is why the American Academy of Actuaries Actuarial Standards of Practice (ASOP) requires that in any actuarial report, "the data used should not only be fully described but also fully displayed in the report so other actuaries can verify the data quality and understand how the data were used." (ASOP 41; Section 3.2) In addition, "Any potential bias in the data should be disclosed." (ASOP 23; Section 3.7 and 4.1) Also, "[a]n actuary who is not financially, organizationally, or otherwise independent concerning any matter related to the subject of an actuarial communication should disclose any pertinent information that is not apparent. This includes any situation where an actuary acts, or may appear to be acting, as an advocate." (ASOP 41; Section 3.4.3)

[11] Robert Glatter, M.D., "Medical Malpractice: Broken Beyond Repair?" *Forbes*, February 6, 2013, http://www.forbes.com/sites/robertglatter/2013/02/06/medical-malpractice-broken-beyond-repair/.

[12] RAND Institute for Civil Justice, "RAND Institute for Civil Justice Board of Overseers" (January 2013), http://www.rand.org/jie/research/civil-justice/about/overseers.html.

[13] *See*, *e.g.*, The Doctors Company press release, "The Doctors Company Hosts Tort Reform Summit," October 3, 2001, http://www.freedomworks.org/news/the-doctors-company-hosts-tort-reform-summit.

[14] The Doctors Company press release, "The Doctors Company Co-hosts Sixth Annual Legal Reform Summit," October 24, 2005, http://www.thedoctors.com/TDC/PressRoom/PressContent/CON_ID_000268.

[15] *See*, *e.g.*, "The Doctors Company and Michigan State Medical Society Partner on Bills," *Claims Journal*, January 11, 2013, http://www.claimsjournal.com/news/midwest/2013/01/11/220731.htm.

[16] Robert Glatter, M.D., "Medical Malpractice: Broken Beyond Repair?" *Forbes*, February 6, 2013, http://www.forbes.com/sites/robertglatter/2013/02/06/medical-malpractice-broken-beyond-repair/.

even mentioned as a data limitation. In other words, these figures were calculated by throwing together the claims history of the vast majority of good doctors (82 percent of whom have never had a medical malpractice payment since the National Practitioner Data Bank was created in 1990[17]) with a group that includes incompetent physicians with long malpractice histories – some with 10 or more payments.[18] This was in order to achieve an "average," suggesting that all doctors should fear spending a good chunk of their careers fighting claims. Relying on statistics based on this kind of methodology is manipulative and not helpful to the debate.

We understand that there are many claims that result in no payment and that these still need to be defended. However, claims are not lawsuits. It is wrong to interchange these concepts as the researchers did at least in some parts.[19] As Cornell Law School Professor and empirical scholar Theodore Eisenberg explained in his April 2012 article *The Empirical Effects of Tort Reform,*[20]

> [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.

As to litigation costs, which CAP suggests are high when insurers lose and average $17,130 when they win, there are the same data problems as in the previous analysis. In addition, as with much of the discussion about system costs, there seems to be an almost inexplicable resistance to hold insurers largely responsible for driving up costs. Nothing today prevents providers or liability carriers, like The Doctors Company, from settling legitimate claims with patients before they file a court case or from paying valid claims expeditiously. Yet they do not. They would prefer to fight patients often by denying, delaying and defending against legitimate claims. And by pursuing this strategy, they are profiting handsomely. In recent years, 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

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[17] *See* Public Citizen's Congress Watch, *The Great Medical Malpractice Hoax: NPDB Data Continue to Show Medical Liability System Produces Rational Outcomes*, (January 2007), http://www.citizen.org/publications/publicationredirect.cfm?ID=7497#14.

[18] The number of physicians with these kinds of horrendous malpractice records is no surprise considering that, "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." *Id.*

[19] These data come from an insurer's closed claims study, which does not distinguish payments made during the course of litigation. Yet in the methodology section, the following statement is found: "Finally, we analyzed data on physician age to estimate the cumulative career malpractice risk of being sued at least once by a given age for both high- and low-risk specialties." Anupam B. Jena, M.D. et al., "Malpractice Risk According to Physician Specialty," 365 *N Engl J Med* 629 (August 2011), http://www.nejm.org/doi/full/10.1056/NEJMsa1012370#t=articleMethods.

[20] Theodore Eisenberg, "The Empirical Effects of Tort Reform," *Research Handbook on the Economics of Torts* (forthcoming); Cornell Legal Studies Research Paper No. 12-26, April 1, 2012, http://ssrn.com/abstract=2032740.

2009."[21] (For more information, *see* an October 2012 California Department of Insurance news release.[22]) Clearly, trying to come up with legal system solutions instead of tackling the insurer's obvious role in driving up litigation costs is misguided.

"DEFENSIVE MEDICINE"

Dr. Fred Hyde, Clinical Professor in the Department of Health Policy and Management at Columbia University's Mailman School of Public Health,[23] defined "defensive medicine" this way:

> 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.[24]

Clearly, most physicians in the country are not engaged in this practice. We believe most physicians are good doctors who order tests and procedures for the very reasons that they certify to Medicare and Medicaid – because they are medically indicated.[25] They are practicing good medicine. As one physician participating on a listserve about this topic recently explained: "As a physician, the first problem I face is what does it mean to say a test is 'unnecessary.' The term suggests that tests live in two categories, those that are helpful and those that are not, but in reality what we're really dealing with is a continuum of probability." Perhaps some doctors do commit Medicare fraud, and clearly "fee-for-service" medicine creates a perverse incentive for providers to do too many tests. But it certainly is the lesson of history that even if you remove litigation as a factor, the extent of tests and procedures ordered will not change.

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[21] Shaya Tayefe Mohajer, "Calif regulator: Malpractice insurance too pricey," *Associated Press,* February 18, 2011, http://www.businessweek.com/ap/financialnews/D9LF7C300.htm.

[22] 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.

[23] Dr. Hyde holds both medical and law degrees from Yale and an MBA from Columbia, consults for hospitals, physicians, medical schools and others "interested in the health of hospitals," has served twice as chief executive of a non-profit hospital and as vice president of a major university teaching hospital.

[24] Fred Hyde, M.D., Clinical Professor, Department of Health Policy and Management, Columbia University Mailman School of Public Health, "Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussions; Is There a Role for ACOs, CER, PCORI and 'Health Reform' in 'Tort Reform'" (2010). The article was funded by a grant from the Center for Justice & Democracy and has been submitted for publication.

[25] *See*, *e.g.*, U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H-6O2. Washington, D.C.: U.S. Government Printing Office, July 1994, http://biotech.law.lsu.edu/policy/9405.pdf (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." Moreover, the effects of "tort reform" on defensive medicine "are likely to be small.")

The $5 Billion "Savings"

The section of the SPP titled "Reduce the costs of defensive medicine" has a $5 billion "savings" figure attached to it. There is no substantiation or backup for this. Before delving into the advisability of basing policy on the concept of "defensive medicine" at all, we will briefly explain why the $5 billion number itself seems far-fetched.

First, in over 30 years, medical malpractice premiums and claims have never been greater than 1% of our nation's health care costs.[26] In 2009, the Congressional Budget Office issued an analysis of cost savings from "tort reform."[27] Of the 0.5% in overall health care savings CBO found, 0.3% was attributed to "slightly less utilization of health care services" or "defensive medicine." Many believe that these numbers, low as they are, are still exaggerated.[28] However, it is nearly equal to what CAP says will be saved by its proposal. Yet CBO believed that to achieve such defensive medicine "savings," the nation would have to enact a complete menu of draconian tort restrictions. This includes not just a $250,000 cap on non-economic damages, but also a punitive damages cap of $500,000 or two times the amount of economic damages, repeal of the collateral source rule, one-year date of discovery statute of limitations (3 years for children) and repeal of joint and several liability. It is difficult to see how CAP's proposal would save about what CBO scored from nationwide enactment of so many severe tort restrictions that virtually no state has them all. And it would still amount to less than 0.5% of overall health care costs. As Dr. Hyde succinctly put it, "The costs, if any, of defensive medicine, are trivial, in comparison to the cost of health care."[29]

Second, to put all these numbers in context, total medical malpractice payouts – the amount of money we spend to take care of the hundreds of thousands injured by medical negligence each year – are annually about $5 billion and have been relatively stable for years.[30] In other words, litigation-related savings from CAP's proposal purportedly equals what would be saved if every single medical malpractice lawsuit were eliminated, including every legitimate case. This seems equally hard to conceive.

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[26] *See*, Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care* (July 2009), http://insurance-reform.org/pr/090722.html.

[27] Congressional Budget Office, "CBO's Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice ('Tort Reform')," October 9, 2009, http://www.cbo.gov/publication/41334.

[28] *See*, *e.g.*, Letter from Sen. John D. Rockefeller IV (D-WV) to Douglas W. Elmendorf, Director, Congressional Budget Office (Oct. 21, 2009), http://rockefeller.senate.gov/press/102109%20Ltr%20to%20CBO%20on%20Med%20Mal.pdf. *See also*, Statement of CJ&D Executive Director Joanne Doroshow before the U.S. House Committee on Energy and Commerce Subcommittee on Health, "Hearing on The Cost Of the Medical Liability System Proposals for Reform, including H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011," April 6, 2011 at 2, https://www.centerjd.org/system/files/CJDECHealth2011testimonyF.pdf.

[29] Fred Hyde, M.D., "Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussions; Is There a Role for ACOs, CER, PCORI and 'Health Reform' in 'Tort Reform.'" (2010).

[30] *See*, Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care* (July 2009), http://insurance-reform.org/pr/090722.html.

General Problems with the "Defensive Medicine" Argument

As you must know, many experts have said that there are no reliable data showing widespread existence of "defensive medicine," or certainly that liability considerations are ever the exclusive reason why most tests and procedures are performed, which is the definition of "defensive medicine."

In June 2012, the *Journal of Empirical Legal Studies* published a groundbreaking study which examined Medicare spending after Texas enacted severe "tort reform" in medical malpractice cases.[31] The authors[32] found no evidence of a decline in health-care utilization or any impact on so-called "defensive medicine." Among the report's relevant findings:

- "One possibility [as to why "tort reform" doesn't lower health-care spending] 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."[33] In fact, "[l]ower 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."[34]

- 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…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."[35]

Other experts have expressed similar skepticism. Dr. Hyde wrote, "'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."[36]

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[31] Myungho Paik et al., "Will Tort Reform Bend the Cost Curve? Evidence from Texas," *Journal of Empirical Legal Studies* (June 2012), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1635882.
[32] 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; Myungho Paik, Northwestern University School of Law; and Charles Silver, University of Texas School of Law.
[33] *Id.* at 210.
[34] *Ibid.*
[35] *Id.* at 210-11.
[36] Fred Hyde, M.D., "Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussions; Is There a Role for ACOs, CER, PCORI and 'Health Reform' in 'Tort Reform.'" (2010).

Surveys are Misleading

As Dr. Hyde noted above, the other major problem with the "defensive medicine" argument is the almost exclusive reliance on anonymous physician "surveys" to establish its widespread existence, which are then used politically:

> 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….[37]

In these surveys, doctors never actually identify specific tests or procedures they have conducted for the primary purpose of avoiding a lawsuit, let alone a service they would no longer perform if "tort reform" were enacted. Indeed, such surveys are usually conceived by organized medicine, whose purpose is to give the impression of a scientifically-conducted poll, yet they are not. In fact, in 2003, the General Accountability Office (GAO) condemned the use of "defensive medicine" physician surveys, noting everything from low response rates (10 and 15 percent) to 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."[38] 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."[39]

In the June 2010 *Archives of Internal Medicine*,[40] 2,416 doctors were anonymously asked to consider the following two statements and indicate if they agreed or not:

> "Doctors order more tests and procedures than patients need to protect themselves against malpractice suits."
>
> "Unnecessary use of diagnostic tests will not decrease without protections for physicians against unwarranted malpractice suits."

About 9 out of 10 doctors say they agreed. None were asked if they personally engage in the practice (let alone the kind of detail GAO suggested). Like all similar "push poll" surveys, there were no counter viewpoints to provide any balance to these statements, nor were there any follow-up questions asking doctors to identify the specific unneeded tests they may have ordered,

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[37] *Ibid.*
[38] General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care,* GAO-03-836 (August 2003) at 27, http://www.gao.gov/new.items/d03836.pdf.
[39] *Ibid*.
[40] Tara F. Bishop et al., "Physicians' Views on Defensive Medicine: A National Survey," 170 *Arch Intern Med.* 1081 (2010), http://archinte.jamanetwork.com/article.aspx?articleid=416067.

let alone whether they billed Medicare for them.[41] Had these questions been asked, the survey results would undoubtedly have been substantially different.

Another widely-cited "survey" was of 56[42] or 72[43] Pennsylvania orthopedic surgeons, whose respondents claimed that 19.7 percent of the imaging tests they ordered were for defensive purposes. This supposedly amounted 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."[44] (We thought it was important to discuss MRI's since CAP itself points to this test as an example of one that would benefit from the "safe harbor" immunity protection.) Dr. Hyde reviewed this study when it was first reported and found:

> [A] moderator [of the podium presentation of this study] 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.[45]

In other words, an MRI may be unnecessary but was done to satisfy insurance requirements. And there are other reasons. As GAO also noted, "[s]ome 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

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[41] 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." *See*, http://www.cms.gov/cmsforms/downloads/CMS1500805.pdf.

[42] This is the number of respondents according to the American Academy of Orthopedic Surgeons' on-line summary of paper presentations slated for February 16, 2011, during the Academy's annual meeting in San Diego. *See* "The prevalence of defensive orthopaedic imaging: a prospective practice audit in Pennsylvania," http://www2.aaos.org/anmeet/anmt2011/podium/119.htm.

[43] This is the number of respondents according to the American Academy of Orthopedic Surgeons' subsequent press release, "Healthcare Spending: Study Shows High Imaging Costs for Defensive Purposes," February 16, 2011, http://www.sciencedaily.com/releases/2011/02/110216082659.htm.

[44] *Ibid*.

[45] Center for Justice & Democracy, "Critique of February 2011 AAOS 'Defensive Medicine' Survey," http://centerjd.org/system/files/AAOScritique.pdf.

that can mitigate defensive practices."[46] Moreover, "[a]ccording to some research, managed care provides a financial incentive not to offer treatments that are unlikely to have medical benefit."[47]

Many have pointed out that one of the biggest cost drivers under Medicare is that physicians are paid by the services they provide and not by outcome. A recent *60 Minutes* investigation on end-of-life care found, for example, that "there 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."[48]

Interestingly, CBO found little evidence of "defensive medicine" except in studies of Medicare, not in studies of private managed care systems. According to CBO, the problem is Medicare's emphasis on "fee-for-service" spending, whereas private managed care "limit[s] the use of services that have marginal or no benefit to patients (some of which might otherwise be provided as 'defensive' medicine)…."[49] In other words, CBO virtually admits that to the extent "defensive medicine" exists at all, it can be controlled through simply managing care correctly as opposed to trying to manipulate legal rules.

Finally, the entire rationale behind the "defensive medicine" argument is that by eliminating lawsuits, doctors will not have to think about liability anymore. Unless absolute immunity were conferred on the entire health care system for all negligence and recklessness that doctors commit, doctors will never stop presenting "defensive medicine" as the reason for tests and procedures. This was well-illustrated in Dr. Atul Gawande's June 2009 *New Yorker* article called "The Cost Conundrum; What a Texas town can teach us about health care," which explored why the town of McAllen, Texas "was the country's most expensive place for health care."[50] The following exchange took place with a group of doctors and Dr. Gawande:

> "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?

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[46] General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care,* GAO-03-836 (August 2003) at 27, http://www.gao.gov/new.items/d03836.pdf.
[47] *Ibid*.
[48] "The Cost of Dying: End-of-Life Care," *60 Minutes*, August 6, 2010, http://www.cbsnews.com/2102-18560_162-6747002.html?tag=contentMain;contentBody.
[49] Congressional Budget Office, "CBO's Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice ('Tort Reform')," October 9, 2009, http://www.cbo.gov/publication/41334.
[50] Atul Gawande, "The Cost Conundrum," *New Yorker*, June 1, 2009, http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande.

> "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.

Or as Dr. Sanghavi noted in his *Boston Globe Magazine* piece, "[S]tudies show that doctors order a lot of questionable testing and treatment even when malpractice risks are very low."[51] While doctors may tell pollsters that tests are done to avoid lawsuits, digging further usually reveals that there are other factors at work. So trying to address overutilization by manipulating the legal system will solve nothing but will continue to make it more difficult for patients who are harmed.

CLINICAL PRACTICE GUIDELINES SHOULD NEVER BE THE LEGAL BASIS FOR DETERMINING WHETHER OR NOT PATIENT HARM WAS THE RESULT OF NEGLIGENCE.

Both sides in malpractice litigation currently make limited use of clinical practice guidelines in settlement negotiations, or even to help lawyers decide whether or not to file suits. However, CAP's "presumed immunity" proposal raises serious concerns.

It is already generally recognized that conflicts of interest and specialty bias are inherent problems in the development of clinical practice guidelines. It is fundamentally unfair for patients to have their cases judged by liability standards chosen by medical and specialty societies, especially since they are written with the knowledge that they will help exculpate fellow physicians. If medical societies are allowed to participate in writing guidelines they know will exempt their members from liability, conflicts of interest and bias will escalate.

And that raises a critical issue: No matter who writes them, it is impossible to develop single authoritative guidelines for every medical condition, let alone to trust any entity to suddenly become the sole arbiter of acceptable medical practice.[52] It is estimated that more than 1,400 sets of clinical practice guidelines exist today. While some standards, such as those in anesthesia, are clear and easily complied with, others, such as in obstetrical cases, are complicated and can be contradictory. Moreover, as they are written for "average patients" and cannot encompass the huge variation in how patients present, there may be good reason to vary from a guideline's patient recommendation. Attempting to establish a single authoritative guideline for a medical condition could result in a loss of confidence in the guideline itself. As explained by Arnold J. Rosoff, Professor of Legal Studies and Health Care Systems at the Wharton School and Senior Fellow at the Leonard Davis Institute of Health Economics, University of Pennsylvania:

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[51] Darshak Sanghavi, M.D., "Medical malpractice: Why is it so hard for doctors to apologize?" *Boston Globe Magazine,* January 27, 2013, http://www.bostonglobe.com/magazine/2013/01/27/medical-malpractice-why-hard-for-doctors-apologize/c65KIUZraXekMZ8SHlMsQM/story.html.

[52] *See*, Arnold J. Rosoff, "Evidence-Based Medicine And the Law: The Courts Confront Clinical Practice Guidelines," 26 *J. Health Pol. Pol'y & Law* 327 (April 2001), http://www.ahrq.gov/clinic/jhppl/rosoff.pdf.

- "[A]chieving such unanimity would require designating some entity, presumably a governmental agency, as the sole arbiter of what is acceptable medical practice. That is practically and politically inconceivable."[53]

- "[K]nowledgeable, respected professional groups can, and often do, come down on opposite sides on a particular treatment issue."[54]

- "Accepting that there will almost certainly be multiple guidelines for many conditions, courts will have to engage in a process of deciding, when guidelines conflict on a material point, which one to treat as authoritative, or more authoritative."[55]

In other words, litigation could escalate. Indeed, the medical profession itself has not accepted clinical practice guidelines as appropriate legal standards, even for exculpatory purposes. This concern led then-American Medical Association (AMA) President Richard F. Corlin, M.D., to testify in 1993 before Congress: "At the present time, insufficient evidence exists to show that clinical practice guidelines can be developed in a manner specific enough to be introduced as an affirmative defense in medical liability litigation."[56] The AMA urged instead "that they be used only as evidence of the customarily observed professional standard of practice and that their degree of authority be dependent upon the degree of their acceptance among medical practitioners."[57]

That is also why, to date, only a few states have attempted to develop and use certain guidelines as legal standards. These limited state experiments, which began and ended in the 1990s, provide no support whatsoever for adoption of guidelines as national policy. For example, in the 1990s, Maine established a program that allowed doctors in four specialties – anesthesiology, emergency medicine, obstetrics/gynecology and radiology – to participate in a program allowing use of guidelines as exculpatory evidence in lawsuits.[58] Other specialties were encouraged to take advantage of this program but did not. The program expired, and the Maine Bureau of Insurance concluded that "the medical demonstration project had no measurable effect on medical professional liability claims, claims settlement costs, or malpractice premiums."[59]

In 1996, Florida also began a demonstration project for cesarean deliveries, but reportedly "garnered relatively little support among physicians – only 20% of physicians eligible to participate chose to do so and the project ended in 1998.... Three other states (Kentucky,

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[53] *Ibid.*
[54] *Ibid.*
[55] *Ibid.*
[56] *Ibid.*
[57] *Id* at 341 (citing American Medical Association 1993: 58; Hirshfeld 1993: 323). As Rosoff states, "It is notable that the AMA's reservation about CPGs was stated even in the context of their defensive use." *Ibid*.
[58] *See*, Linda L. LeCraw, Esq., "Use of Clinical Practice Guidelines in Medical Malpractice Litigation," 3 *J Oncol Pract.* 254 (September 2007), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2793844/.
[59] *Ibid*. (citing Me Bureau of Ins and Bd of Lic in Med, Medical Liability Demonstration Project 2 and 5, 2000).

Maryland, and Minnesota) adopted test projects in the 1990s, though none of the projects is fully operational today (the Maryland and Minnesota projects have fully expired)."[60]

In addition, in some situations, requiring new protocols or guidelines will add costs to the system, increasing the cost of medical care for everyone, including Medicare. In a December 2007 report, CBO summed up the research by concluding that "only a limited amount of evidence is available about which treatments work best for which patients and whether the added benefits of more-effective but more-expensive services are sufficient to warrant their added costs."[61]

Finally, we should note that allowing guidelines to also be used to establish negligence is a positive gesture but does not solve the problem. It does nothing to address the guideline bias issues discussed above. In addition, the patient is always at a disadvantage in the early stages of litigation when the immunity issues would have to be pleaded and decided. As Harvard School of Public Health researchers put it, "[O]ur 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."[62] While the intent may be there, creating a level playing field with "safe harbor" liability protections is impossible.

PATIENT SAFETY

CAP's patient safety goal is based on a desire to reduce unwarranted variation in practice, providing patients with benchmark quality care rooted in science. However, turning guidelines into presumed liability protections could actually harm patient safety.

Very likely, many guidelines will eventually become obsolete. In fact, given how rapidly technological and other advancements are being developed to improve patient care and reduce medical errors, this could happen quickly and often. Under this proposal, doctors will have little choice but to follow an outdated guideline just to get the benefit of the safe harbor provisions. In that case, the incentives work against patient safety.

Here are some recent horrifying statistics about the worsening state of patient safety since the Institute of Medicine's seminal study *To Err is Human*,[63] published well over a decade ago, which found that between 44,000 and 98,000 patients are killed in hospitals each year due to medical errors:

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[60] *Ibid*.
[61] Congressional Budget Office, *Research on the Comparative Effectiveness of Medical Treatments: Issues and Options for an Expanded Federal Role* (December 2007), http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/88xx/doc8891/12-18-comparativeeffectiveness.pdf.
[62] David M. Studdert et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine,* May 11, 2006, at 2030-1, http://gawande.com/documents/ClaimsErrorsandCompensationPaymentsinMedicalMalpracticeLitigation_000.pdf.
[63] Institute of Medicine, *To Err Is Human, Building a Safer Health System*. Washington, D.C.: National Academies Press, 1999.

- A new study led by Johns Hopkins University School of Medicine, published online in the journal *Surgery*, found that surgeons make mistakes called "never events," like leaving behind foreign objects, operating on the wrong site or even the wrong patient, more than 4,000 times a year in the United States. More than 6% of these patients die. Another 32.9% have permanent injuries.[64]

- According to another 2012 study from Johns Hopkins, "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."[65]

- Medical errors occur in one-third of hospital admissions, as much as ten times more frequently than previously estimated.[66] 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.

- Chief medical mistakes uncovered in the Agency for Healthcare Research and Quality 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."[67] 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."[68]
- Of the nearly 1 million Medicare beneficiaries discharged from hospitals in October 2008, about 1 in 7 experienced a serious adverse event (13.5 percent).[69] "An estimated 1.5 percent of Medicare beneficiaries experienced an event that contributed to their

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[64] Johns Hopkins Medicine, "Johns Hopkins Malpractice Study: Surgical 'Never Events' Occur At Least 4,000 Times Per Year," December 19, 2012, http://www.hopkinsmedicine.org/news/media/releases/johns_hopkins_malpractice_study_surgical_never_events_occur_at_least_4000_times_per_year.

[65] Cristine Russell, Senior Fellow, Harvard Kennedy School of Government, "The Alarming Rate of Errors in the ICU," *Atlantic*, August 28, 2012, http://www.theatlantic.com/health/archive/2012/08/the-alarming-rate-of-errors-in-the-icu/261650/, citing Bradford Winters et al., "Diagnostic errors in the intensive care unit: a systematic review of autopsy studies," *BMJ Quality & Safety*, July 21, 2012, http://qualitysafety.bmj.com/content/early/2012/07/23/bmjqs-2012-000803.abstract.

[66] David C. Classen et al., "Events In Hospitals May Be Ten Times Greater Than Previously Measured," *Health Affairs* (April 2011), http://content.healthaffairs.org/content/30/4/581.abstract. *See also*, Chris Fleming, "New Health Affairs: Hospital Errors Ten Times More Common Than Thought?" *Health Affairs Blog*, April 7, 2011, http://healthaffairs.org/blog/2011/04/07/new-health-affairs-hospital-errors-ten-times-more-common-than-thought/.

[67] David W. Freeman, "Hospital errors rampant, study says: What can patients do?" *CBS News*, April 7, 2011, http://www.cbsnews.com/8301-504763_162-20051864-10391704.html.

[68] Steven Reinberg, "Hospital errors more common than suspected," *HealthDay*, April 8, 2011, http://yourlife.usatoday.com/health/healthcare/hospitals/story/2011/04/Report-Hospital-errors-more-common-than-suspected/45929932/1.

[69] U.S. Department of Health and Human Services, Office of the Inspector General, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (November 2010) at i-ii, http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.

deaths, which projects to 15,000 patients in a single month."[70] "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.… Because many adverse events we identified were preventable, our study confirms the need and opportunity for hospitals to significantly reduce the incidence of events."[71]

- "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."[72]

- "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))."[73]

There are now more than enough proven solutions to our patient safety crisis, but they are not being implemented. For example, in the February 2011 *American Journal of Obstetrics & Gynecology*, three physicians published an article about a comprehensive obstetric patient safety program that was implemented in the labor and delivery unit at NY Presbyterian Hospital-Weill Cornell Medical Center, beginning in 2002.[74] This program initially came at the recommendation of the hospital's insurance carrier, MCIC Vermont. For example, they implemented team training and other methods to improve communication, required electronic medical record charting, improved on-call scheduling, established new drug protocols, premixed and color coded solutions, hired full-time patient safety obstetric nurses funded by the carrier, made better use of physicians assistants and put a laborist on staff, required certification in electronic fetal monitoring and held obstetric emergency drills.

The physicians found "that implementing a comprehensive obstetric patient safety program not only decreases severe adverse outcomes but can also have an immediate impact on compensation

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[70] *Id.* at ii.
[71] *Id.* at iii.
[72] Christopher P. Landrigan et al., "Temporal Trends in Rates of Patient Harm Resulting from Medical Care," 363 *N Engl J Med* 2124, 2130, 2133 (November 2010) (citations omitted), http://www.nejm.org/doi/full/10.1056/NEJMsa1004404#t=articleTop.
[73] Theodore Eisenberg, "The Empirical Effects of Tort Reform," *Research Handbook on the Economics of Torts* (forthcoming); Cornell Legal Studies Research Paper No. 12-26, April 1, 2012, at 10, http://ssrn.com/abstract=2032740.
[74] Amos Grunebaum, M.D. et al., "Effect of a comprehensive obstetric patient safety program on compensation payments and sentinel events," *American Journal of Obstetrics & Gynecology* (February 2011), http://www.scribd.com/doc/49879103/Columbia-Presbyterian-Patient-Safety-Study.

payments."[75] For example, they reported that "2009 compensation payment total constituted a 99.1% drop from the average 2003-2006 payments (from $27,591,610 to $250,000). The average yearly compensation payment in the 3 years from 2007 to 2009 was $2,550,136 as compared with an average of $27,591,610 in the previous 4 years (2003-2006), a yearly saving of $25,041,475 (total: $75,124,424) during the last 3 years."[76]

Similarly, CRICO, the insurer for the Harvard hospital system, has implemented an extensive patient safety program.[77] Both these examples show that insurers could be doing much more to insist on error reduction. Unfortunately, many hospitals lack the finances of a NY Presbyterian Hospital-Weill Cornell Medical Center, which can spend to improve care. For too many health care providers, mistakes pay. The cost of a mistake for some hospitals is just insurance, while the cost of improving care and losing reimbursements could be real money to a hospital or provider. These perverse incentives must be changed, and we appreciate CAP's efforts to help accomplish this. In other words, trying to solve this complicated problem on the backs of patients who are brain-damaged, blind, quadriplegic or have lost a child is the wrong approach.

OTHER SOLUTIONS

We noted in our letter that CAP's biggest mistake was not bringing experienced plaintiff or consumer representatives into this process, particularly those individuals who have been through this exercise a number of times in other contexts. In fact, there are actually legal solutions at the state level that would cut down on the number of claims against physicians and would not increase legal burdens on patients.

For example, as soon as someone is injured or killed, state statue of limitations laws begin to run. These laws provide strict time limits for filing a lawsuit. An attorney is obligated to protect his or her client's rights before the statute runs, and so initially they must file against every possible institution, doctor and health care provider. Later, many claims are dismissed. This process understandably annoys and frustrates doctors. In fact, no one is happy about it, but that's the law.

When I served on a medical malpractice task force in New York, doctors and lawyers both saw value in a concept called "enterprise notification." Rather than requiring a plaintiff to commence a lawsuit against every potential defendant, toll the statute of limitations against all health care providers upon the filing of a complaint against one defendant. A doctor is then only brought into the suit if and when the evidence suggests they should be.

There is also a new law in Massachusetts that may be worth exploring. This law was drafted by doctors and lawyers together, and my understanding of how it works is as follows: when a medical malpractice attorney takes on a client, notice is sent to the provider triggering a six-month waiting period. The provider is required to honestly disclose to the patient what happened and, during the waiting period, the parties negotiate toward a possible settlement. If a settlement

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[75] *Ibid*.
[76] *Ibid*.
[77] *See*, *e.g.*, CRICO, "Clinician Resources," http://www.rmf.harvard.edu/Clinician-Resources/#essay.

is reached, no lawsuit is filed. This benefits the doctor quite a bit. If the parties cannot agree and a suit is filed, the disclosure and any apology are kept out of court unless the provider's explanation differs from their original position. In that case, the earlier disclosure may be admitted.

Here the providers recognized that they had neither the knowledge nor proper perspective to develop wise and acceptable legal rule changes on their own. We hope the next time CAP develops legal solutions, all stakeholders participate, not just the providers.