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Analysis of HHS Patient Safety and Medical Liability Initiative Demonstration Grant Proposal for New York State

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We are in receipt of the HHS Patient Safety and Medical Liability Initiative Demonstration Grants proposal that was awarded to Judy Kluger, J.D., New York State Unified Court System in the amount of $2,999,787. This proposal was not publicly disclosed until the *New York Law Journal* published it on June 16, 2010,[1] so we have not had an opportunity to comment on it until now. (Notably, HHS is releasing no grant proposals without a Freedom of Information Act request.)

This grant money proposes to establish a system, which we will identify herein as the "experiment," which is extremely problematic. It envisions a legal process that will begin in five hospitals for all patients who have been killed or injured due to surgical or obstetrical errors. These hospitals are: Beth Israel Medical Center, Maimonides Medical Center, Montefiore Medical Center, Mount Sinai Medical Center, and New York Presbyterian Hospital - Columbia Presbyterian Center. Notably, these hospitals were selected because, among other things, "each has a well-established patient safety infrastructure and, most importantly, the engaged and motivated leadership needed to successfully implement the NYS Model and to influence other hospitals in the state to follow suit." Yet three of these hospitals - Maimonides Medical Center, Montefiore Medical Center, Mount Sinai Medical Center, and New York Presbyterian Hospital - Columbia Presbyterian Center – have such patient safety problems that they have been put on a "watch list" due to "below-average safety performance" in a patient safety analysis conducted by Niagara Health Quality Coalition for Hearst Newspapers.[2]

The investigatory process to determine if malpractice occurred in each case will be either controlled or substantially influenced by hospital administrators or someone from the health care industry, essentially defendants in malpractice cases. Initially, a hospital's lawyer, risk manager and staff will decide if they believe malpractice occurred. If they say yes, they make an early offer of compensation to the patient, who has received no expert legal or medical advice as to whether to accept. If the hospital decides that no malpractice occurred, the patient will be expressly warned that the hospital will fight them court. If the patient decides to go to court anyway, their case will be assigned to a judge, who has received training from medical societies, i.e., groups who represent defendants in malpractice cases. These judges will be advised by a vaguely-defined individual with medical training who will decide, on their own and behind closed doors, if malpractice occurred. This judge will then pressure the patient to negotiate, based on what this advisor tells them.

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[1] Noeleen G. Walder, State Gets $2.9 Million U.S. Grant To Reduce Malpractice Suit Costs, *New York Law Journal,* June 16, 2010.

[2] Cathleen F. Crowley, "Mistakes, advances in New York's hospitals," *Albany Times-Union,* September 20, 2010.

Evaluation and definiation of this program's "success" has been placed in the exclusive hands of its biggest proponent, Michelle Mello of the Harvard School of Public Health.

The experiment, as proposed, is unethical. It violates the legal rights of patients. It contains provisions that could increase medical errors. It skirts legislative authority. It flouts basic notions of transparency. It is riddled with inaccuracies, so much so that we are concerned that HHS has been significantly misled by this document.

The following expresses some of our concerns.

THE EXPERIMENT IS UNETHICAL

This research "experiment" is designed to evaluate whether various interventions are successful in achieving safer care, faster compensation for injured patients and lower costs. Whether or not the program will accomplish any of these objectives is not yet known. Since it is an experiment involving human subjects, all of the issues that pertain to clinical trials are of concern here. Legal and ethical rules must be followed to protect the rights of any prospective participant.

At a minimum, patients must be able to opt in or out of this experiment without prejudice. There is nothing in this proposal that even contemplates that option. There is no evidence that patients will fully understand what they are being asked to participate in and what they are giving up or gaining by doing so. There is no protection against coercion, which is of particular concern for the underserved populations that the five hospitals are touted as serving. There is no mention of the need for a clearly articulated, strictly enforced "informed consent process" (pre-treatment, exceedingly clear disclosure of potential risks and problems) with full Institutional Review Board (IRB) review and approval required.

Like drug trials, people who are expected to participate in this experiment must be shielded from any harm that could result from it. For example, at a minimum, when there is an injury with serious complications that might not be known for some time, no layperson will ever be capable of making a reasoned decision without the assistance of counsel or their own expert. These patients could be extremely harmed by this system. It is unethical for any of those cases to be put into an early offer process.

In sum, legal and ethical rules for research projects involving human subjects, which this experiment is, seem to have been completely thrown out the window under this proposal.

THE EXPERIMENT VIOLATES THE LEGAL RIGHTS OF PATIENTS.

The Disclosure and Early Settlement

The experiment contemplates that after an incident of possible malpractice, the hospital's lawyer, risk manager (insurer) and medical personnel conduct a "rapid investigation" to decide if malpractice occurred and what the compensation should be. The point, apparently, is for the hospital to decide all of this before the patient becomes suspicious and consults an attorney. In

other words, the injured patient is rendered virtually powerless in this process and at the mercy of the hospital, who gets to them first.

There is little doubt that an uninformed patient, particularly one who is catastrophically injured, will be pressured by the hospital to resolve their case for a fraction of what they need or deserve, particularly when it comes to future medical expenses. As noted above, no lay person will ever be capable of making a reasoned decision as to what they may need, such as in the case of a brain-injured newborn, without the assistance of counsel or their own expert.

This absence of legal counsel to assist the patient is not a minor point when it comes to determining the facts surrounding any malpractice case. As Michelle Mello and her colleagues at the Harvard School of Public Health found, "our findings underscore how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information that litigation triggers."[3]

If the hospitals determines that no malpractice occurred, they would then warn the patient that if a lawsuit is filed, the hospital would "vigorously" fight them in court. This is clearly designed to intimate the unprotected patient from exercising his or her right to go to court. It also seems to interfere directly with the fiduciary relationship between the hospital and the patient, in which the patient's interests are supposed to be paramount. It is entirely unclear what authority New York State has to fund a private party to do that.

This experiment is based on the University of Michigan system, whose head, Rick Boothman, is a project consultant. Boothman touts his program as a success, and indeed it is hard to hear about patients who feel differently. None are mentioned in this proposal. However, they clearly exist and the *Washington Post* tracked down one.[4]

Her name is Michelle Hereford, a hospital administrator who is trained as a clinical nurse. In other words, unlike most family members, knew quite a bit about appropriate patient care. Hereford's 44-year-old husband and leukemia patient was killed after his bowel was perforated during surgery at a University of Michigan hospital, and fecal material spread into the rest of his body and gave him sepsis. Michelle tried to get the hospital to respond to increasing symptoms that she witnessed but even with her expertise, she failed. She filed a complaint with the University of Michigan Medical Center, claiming that the perforation in his bowel was diagnosed too late. Rick Boothman apologized to her but admitted no mistake, instead issuing a patronizing statement that she wasn't in the loop with the other doctors treating her husband. She put it this way: "It was a canned letter. It was not an admission, and it wasn't a denial. They're minimizing their risk." This experience spurred Michelle into become a patient safety activist, we assume to try to fix the University of Michigan system.

Judge Directed Negotiation Program

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[3] David M. Studdert, Michelle Mello, et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine,* May 11, 2006.

[4] Lisa Rein, Blaming the Hospital, A Widow Turns Activist; She Says the Staff Was Unresponsive, *Washington Post*, July 21, 2009, found at http://www.washingtonpost.com/wpdyn/content/article/2009/07/20/AR2009072002298.html

Assuming the patient has the courage at this point to exercise their right to file a lawsuit, the systems remains extremely biased against them. "All lawsuits against one of the five participating hospitals will be directed to a participating judge immediately." The patient is bound by this.

First, the experiment contemplates that the medical training for these judges will come from "the Medical Society of the State and New York and other physician associations." It is an enormous conflict of interest if medical and specialty societies are allowed to provide judges with one-sided information they know will be exculpatory for their members.

At the October 29, 2007 meeting of the New York State Medical Malpractice Liability Advisory Task Force, which was supposed to be a discussion of ways to improve patient safety, DOH Commissioner Daines allowed Dr. Richard Berkowitz, representing the American College of Obstetricians and Gynecologists (ACOG), to conduct a 45-minute one-sided presentation on this group's view of the "science" around obstetrical injuries. Following this monologue, one consumer/patient representative took the microphone and voiced an official protest of the conduct of the task force, noting the sweeping, unrebutted generalizations that ACOG was permitted to make, which they no doubt raise in litigation - and lose. Following this protest at the close of that meeting, DOH Commissioner Daines said he "just wants to know the science." He was told there is another view of the "science". He said that perhaps the task force should have a separate meeting to discuss this. This never transpired. This is a good example of what can be expected when medical societies "train" judges.

The judge will get the parties together for a meeting "before attorneys develop a strong sense of personal investment in the case." That would apply only to the patient's attorney since the hospital's attorney has already not only invested in the case, but also made a decision. It's also before the patient has had opportunities to conduct much discovery or do a proper investigation of the case, which the Harvard School of Public Health found so valuable.

Further, the judge "will be assisted by a dedicated Medical Advisor/Program Coordinator funded by the demonstration project, ideally a registered nurse with a law degree." There is nothing in this experiment to prevent this individual from coming directly from medical societies or the health care industry who are defendants in cases, bringing additional partiality to an already biased process. Apparently believing the parties' experts to be of no value, the judge will rely instead on this advisor, who not only may have preconceptions, but also may be dealing with factual circumstances far beyond their own expertise or competence. This possibly biased and/or incompetent individual is given the extraordinary job of deciding, "if the standard of care was violated, causing injury," and then advising the judge. So the factual determinations, on which the court is expected to rely, would be done secretly behind closed doors, no opportunities for the patient to challenge any substantive shortcomings, and all rules of evidence are thrown out the window.

THE EXPERIMENT CONTAINS PROVISIONS THAT COULD INCREASE MEDICAL ERRORS

The Culture of Safety

Part 1 of the proposal deals with initiatives to promote a "culture of patient safety" at participating hospitals. There is nothing different or unusual about these measures. They are all "out of the

literature" and there is nothing wrong with them. However, the lesson of history is that these kinds of measures are insufficient on their own to achieve a "culture of safety" at a hospital.

It has been over a decade since the Institute of Medicine's seminal study "To Err is Human"[5] was published and experts agree that progress has been slow at best at achieving a meaningful reduction in medical errors. In January 2000, then New York State Health Commissioner Antonia Novello pledged to meet the Institute of Medicine's goal of a 50 percent reduction in hospitals' medical errors within five years. Not only was this not accomplished in five years, it is now 10 years later and there is no evidence that any such progress has been made. In fact, things have likely gotten worse. The experiment contains no new or obvious incentives for hospitals to suddenly and robustly embrace these "proactive" safety initiatives, which they haven't done so for the last 10 years. And since all of the evaluation and reporting of data to measure the success or failure of these programs is internal, whatever published results they achieve will be suspect.

Moreover, the proposal relies heavily on the New York State Department of Health (DOH), asserting, "DOH has a long record of successful patient safety initiatives." DOH is supposed to "recommend new, proactive patient safety measures to the hospitals." Yet the record of DOH in accomplishing one of its most important patient safety jobs - sanctioning repeat-offending doctors who should not be practicing - remains a national disgrace. In June 2010, NYPIRG wrote and consumer groups released a new study of DOH's progress in this area, called *System Failure A Review Of New York State's Doctor Discipline System*. Noting that in 2008, "After news reports on the failures of the state Health Department to aggressively monitor and sanction a grossly substandard physician practicing on Long Island, Governor Paterson and the legislature approved legislation to improve the state's oversight of doctors." Yet the data show that "New York is now taking fewer actions against physicians than at any time since 1995, despite reforms, additional resources, a swelling number of physicians, and a goal of reducing medical injuries." Moreover, "While the number of actions has declined it is clear that there has not been a reduction in complaints."

The experiment claims to enhance patient safety by encouraging more adverse event reporting. At the same it, it stresses that such reporting will not result in punitive actions. Instead of doing more to weed out poorly performing physicians, this proposal contemplates possibly allowing New York to become a safe harbor for them. Shockingly, it contemplates leaving it up to ***each hospital*** to decide, "Will payments made under this program necessitate reports to the National Practitioner Data Bank, state closed claims database, or regulatory bodies?" In other words, the hospital decides whether ***anyone*** – the public, other hospitals, DOH – ever hears about its own negligent physicians. Not only does this violate the intent of patient safety laws, it will create a situation where New York State becomes a safe harbor for incompetent doctors. This is exactly what has happened in other states that have tried "alternative compensation" cover-up systems like this.

For example, one of the most dangerous aspects of Virginia's disastrous "alternative litigation" program – its Birth-Related Neurological Injury Compensation Program[6], which has been in place for two decades - is its failure to hold accountable even the worst practitioners and allowing them to continue practicing. National birth-injury experts expressed fear about Virginia becoming a safe

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[5] *To Err Is Human, Building a Safer Health System,* Institute of Medicine, 1999.

[6] See, e.g., Bill McKelway, "Study Faults Program for Brain-Injured; Shortcomings Found in Care for Children," *Richmond Times Dispatch*, Nov. 13, 2002; Liz Szabo & Elizabeth Simpson, "Birth Injuries Get 'Minimal Review; State Report Says Board Must Hold Doctors Accountable," *Virginian-Pilot*, Nov. 15, 2002.

harbor for bad doctors because of a lack of disciplinary actions under this law.[7] "The birth-injury cases … are not reported to national databases that track actions against doctors and measure physicians' insurability. With no court action, settlement or disciplinary actions, a doctor's involvement in birth-injury cases can go undetected."[8] In fact, rarely if ever has the program produced a disciplinary action against a hospital or doctor, even though those cases "pose a high risk for findings of negligence against doctors, nurses and hospitals."[9]

In sum, this experiment calls into serious question the continuation of accountability mechanisms that are currently in place to deter errors, with the possibility of significant deleterious effects on patient safety

Removing the fear of litigation will not change the culture of secrecy at hospitals

The early disclosure aspect of the experiment envisions an idealized system where physicians and hospitals will simply admit mistakes to unrepresented patients because they will no longer have to fear litigation. This is completely bogus. Fear of litigation is not the reason hospitals and doctors do not report errors or communicate with their patients.

David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law, and Charles Silver of the University of Texas at Austin School of Law, who have studied this problem, write, "[e]xhaustive chronicles of malpractice litigation's impact on physicians never once assert that physicians freely and candidly disclosed errors to patients once upon a time, but stopped doing so when fear of malpractice liability increased. Instead, the historical evidence indicates that there was never much *ex post* communication with patients, even when liability risk was low."[10]

In his book on medical malpractice, Tom Baker, then Connecticut Mutual Professor of Law and Director of the Insurance Law Center at the University of Connecticut School of Law, confirmed, "to prove that lawsuits drive medical mistakes underground, you first have to prove that mistakes would be out in the open if there were no medical malpractice lawsuits. That is clearly not the case."[11]

Similarly, a May 11, 2006 article in 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."[12] Other studies have produced similar results.

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[7] Bill McKelway, "Danville Has High Birth-Injury Rate; Critics Say Virginia Law Shields Doctors from Lawsuits," *News Virginian*, June 1, 2003.
[8] Bill McKelway, "Brain Injuries Spur No Action; Case Review, Required by Law, Is Not Being Done, Va. Study Found," *Richmond Times Dispatch*, Jan. 14, 2003.
[9] Bill McKelway, "Brain-Injury Program's Outlook Dim; Cost Savings for Doctors Meant Less for Children," *Richmond Times Dispatch*, Nov. 16, 2002.
[10] David A Hyman and Charles Silver, "The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?," 90 Cornell L. Rev. 914 (2005).
[11] Tom Baker, *The Medical Malpractice Myth* (2005) at 97.
[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.

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 Medicine*, "Comparisons of how Canadian and U.S. doctors disclose mistakes point to a 'culture of medicine,' not lawyers, for their behavior."[13] 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."[14]

Another example is in Massachusetts, where nearly all hospitals fall under the state's charitable immunity laws that cap their liability at $20,000. Yet 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.[15]

Hyman and Silver offer a number of explanations for physicians failure to report errors: a culture of perfectionism within the medical profession that shames, blames, and even humiliates doctors and nurses who make mistakes; fragmented delivery systems requiring the coordination of multiple independent providers; the prevalence of third-party payment systems and administered prices; overwork, stress, and burnout; information overload; doctors' status as independent contractors and their desire for professional independence; the Health Insurance Portability and Accountability Act (HIPAA); a shortage of nurses; and underinvestment in technology that can reduce errors.[16]

They write, "it is naive to think that error reporting and health care quality would improve automatically by removing the threat of liability."[17]

Given the recent heightened criticism of the DOH for failing to discipline or sanction the state's worst doctors, including those with 10 or more malpractice payments like Dr. Finkelstein in Long Island, less accountability is obviously the wrong direction for this state right now.

THE EXPERIMENT SKIRTS LEGISLATIVE AUTHORITY.

Repeated throughout this proposal are statement like: "Importantly, it requires no legislative action to proceed," and "The NYS model, if successful, will demonstrate that hospitals … can advance medical liability reform without legislation." The goal of avoiding the legislative process, which is accountable to the voters of New York State, cannot be clearer.

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[13] 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.

[14] *Ibid*.

[15] Doug Most, "The Silent Treatment," *Boston Magazine*, Feb. 2003.

[16] David A Hyman and Charles Silver, "The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?," 90 Cornell L. Rev. 897-99 (2005); Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007).

[17] *Ibid*.

As has been demonstrated above, the experiment forces patients into a biased process. It contemplates eliminating or restricting longstanding common law rights for patients in five hospitals. Some victims of malpractice would lose their ability to obtain the same level of compensation that those with access to the legal system, with an impartial judge or jury, listening to the facts of each individual case, might assess.

In other words, this federal grant is essentially a state subsidy designed to have someone forgo the same access to the courts as everyone other patient under state law, and which is grounded in the state constitution. In order for OCA to simply waive New York common law in this way and bind a patient to this process, there must be legislative authority to do so.

THE EXPERIMENT FLOUTS BASIC NOTIONS OF TRANSPARENCY.

As mentioned earlier, all of the evaluation and reporting of patient safety data to measure the success or failure of this experiment is internal. The decision as to whether to report any incidents of malpractice discovered in the early offer stage to the National Practitioner Data Bank, state closed claims database, or regulatory bodies, is left entirely in the hospitals discretion. In other words, there is no requirement for any transparency.

Moreover, the evaluation of the success of the "early offer" and "judge-directed negotiation" elements of this experiment will not be done by a neutral observer, but rather has been placed in the hands of one of its the biggest proponents, Michelle Mello. As an promoter of this precise program and others like it,[18] Michelle Mello should not be allowed anywhere near this evaluation process. Yet as far as we can tell, she will hold all the data and will guide the findings and conclusions, which no outside neutral observer will even see, let alone get a chance to evaluate.

Mello's participation in this project is deeply troublesome. She not only leads a small group of researchers at the Harvard School of Public Health that have been the main academic proponents of this very model, but also she has consultancy arrangements[19] with an industry-funded[20] front group, Common Good, founded by corporate lawyer Philip K. Howard. Common Good promotes "health courts" that contain features similar to this experiment, like trained judges and medical advisors. Notably, Common Good is specifically mentioned in this proposal as part of the "dissemination effort", to the exclusion of New York public interest groups with long, distinguished histories of advocating for the rights of consumers and patients, and who may object to this experiment.

Mello's Common Good relationship was not disclosed in this proposal. In fact, she has failed to disclose it in other government proposals advocating similar systems,[21] as well as numerous academic writings.[22] But even if it were disclosed, the closeness of her project at Harvard to this

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[18] See e.g., Michelle M. Mello, J.D., Ph.D., and Thomas H. Gallagher, M.D., "Malpractice Reform — Opportunities for Leadership by Health Care Institutions and Liability Insurers," *New England Journal of Medicine*, March 31st, 2010; found at http://healthcarereform.nejm.org/?p=3215&query=home

[19] See, http://content.nejm.org/cgi/data/NEJMp1001603/DC1/1

[20] Common Good does not deny that up to 1/3 of its budget comes from corporate sources. http://commongood.org/learn-faq.html

[21] See, e.g., Evaluation of Options for Medical Malpractice System Reform; A Report to the Medicare Payment Advisory Commission (MedPAC); January 29, 2010

[22] See, e.g., Siegal G, Mello MM, Studdert DM. Adjudicating severe birth injury claims in Florida and Virginia: The experience of a landmark experiment in personal injury compensation. Am J Law Med 2008;34:489-533.

industry-funded front group[23], and her history virtually campaigning for adoption of such measures, should completely disqualify her from any evaluation role of this experiment.

THE PROPOSAL IS RIDDLED WITH INACCURACIES AND MYTHS

The point of departure for this entire experiment is that "New York's medical malpractice system is widely considered to be broken." We absolutely disagree with that statement. The proposals' support for this viewpoint is full of inaccuracies. The authors malign the civil justice system, fundamental to our democracy, based on myths. Here are among the misrepresentation made to the government in this proposal.

Misrepresentation: New York Has No Tort Reform

The proposal asserts that New York would serve as an excellent proving ground for this experiment because it has no tort reform. There are repeated references to the "absence of tort reform" in New York State. "New York has not yet made significant headway reforming the medical liability system." It is completely untrue, and patients here have already paid dearly for the tort reform already on the books.

In the mid-1980s, New York limited joint and several liability, repealed the collateral source rule, established structured settlements and imposed severe limits on contingency fees for lawyers in medical malpractice cases, making it less likely that legitimate cases can be brought. New York has one of the most archaic wrongful death law in the country, making it impossible for many malpractice cases to be brought at all. What's more, the statute of limitations, one of the only "tort reforms" touted in Section C.3, "Medical Liability Reform," is one of the most restrictive in the nation: 2 ½ years from the date of the negligent act. That means patients whose misdiagnose leads to later cancer are virtually without recourse here. Only a handful of states have shorter time period in which a victim of medical negligence is allowed to bring a claim. This "tort reform" is so unfair that New York judges have called upon the legislature to change it. To suggest that New York patients do not already have tort reform obstacles to overcome is badly misleading.

(presented a version of this at a Common Good- sponsored event in New York on June 3, 2008 re: instituting a similar process in NYC. (Event materials/bio contained no linking of Mello with Common Good); Mello MM, Studdert DM, Moran P, Dauer EA. Policy experimentation with administrative compensation for medical injury: issues under state constitutional law. Harvard J Legis 2008;45:59-106 (Main paper presented for a Common Good forum in DC on Nov. 5, 2007 – no ties acknowledged); Kachalia AB, Studdert DM, Brennan TA, Mello MM. Beyond negligence: avoidability and medical injury compensation. Soc Sci Med 2008;66:387-402 (presented a slideshow on negligence and medical malpractice at a Common Good forum on Oct. 15, 2007 in Cheyenne, Wyoming – speaker bio indicates no relationship with Common Good); Mello MM, Studdert DM, DesRoches CM, Peugh J, Zapert K, Brennan TA, Sage WM. Caring for patients in a malpractice crisis: physician satisfaction and quality of care. Health Aff 2004;23:42-53. Studdert DM, Mello MM, Gawande AA, Gandhi TK, Kachalia A, Yoon C, Puopolo AL, Brennan TA. Claims, errors, and compensation payments in medical malpractice litigation. N Engl J Med 2006;354:2024-2033.

[23] See e.g., Ending Malpractice Roulette, Harvard Public Health Review, Summer/Fall 2005. ("An unusual feature of the project, funded with $1.5 million from the Robert Wood Johnson Foundation, is the partnership between HSPH researchers and Common Good. Pairing the advocacy organization with the Harvard academics was deliberate, according to Nancy Barrand, the RWJF program officer who collaborated with Harvard in proposing the project to the foundation. 'Common Good is hoping to pave the way to test this idea, but they can't do it without the development work that Harvard needs to do,' she says. 'And Harvard isn't going to go forward without the advocacy of Common Good to get political buy-in.'") http://www.hsph.harvard.edu/review/review_fall_05/rvwfall05_malpractice2.html

Misrepresentation: New York Has Dual Problems Of "Frivolous Lawsuits" and High Insurance Premiums, Which This Will "Solve"

There is not an ounce of support for the statement that frivolous lawsuits are a problem in New York, either in the proposal itself or in reality. In 2007, the New York State Department of Insurance stated clearly in a presentation to the New York State Task Force on Medical Malpractice, entitled "Good News," that claims frequency was not only down, but "at a new low and has been stable for the third straight year. Severity is increasing at just 3 percent annually."

Nothing has changed in the intervening three years. In fact, according to National Practitioners Data Bank data,[24] in New York State:

- Medical malpractice payments continue to be remarkably stable both as to the number of physician payments (frequency) and the aggregate amount paid to injured patients (severity).

- The aggregate amount paid to injured patients in New York for malpractice judgments and settlements has dropped dramatically since 2006.

- When viewed over a longer period of time, aggregate malpractice payments in New York have risen at roughly the same rate as overall inflation from 1993 through 2009.

- The frequency of malpractice payments has declined, even though there has been a dramatic increase in the number of doctors practicing in New York.

The authors' decision to cherry-pick statistics from a 2006 Harvard study to try to find support for the notion that frivolous lawsuits are a problem nationally is particularly outrageous. Harvard's own May 10, 2006 new release announcing the study was entitled " Study Casts Doubt on Claims That the Medical Malpractice System Is Plagued By Frivolous Lawsuits." To quote directly from the release:

> One popular justification for tort reform is the claim that "frivolous" medical malpractice lawsuits—those lacking evidence of substandard care, treatment-related injury, or both—enrich plaintiffs' attorneys and drive up health care costs. A new study by researchers from the Harvard School of Public Health (HSPH) and Brigham and Women's Hospital challenges the view that frivolous litigation is rampant and expensive. …
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> "Some critics have suggested that the malpractice system is inundated with groundless lawsuits, and that whether a plaintiff recovers money is like a random 'lottery,' virtually unrelated to whether the claim has merit," said lead author David Studdert, associate professor of law and public health at HSPH. "These findings cast doubt on that view by showing that most malpractice claims involve medical error and serious injury, and that claims with merit are far more likely to be paid than claims without merit."

Also mentioned in the proposal's "Literature Review" is discussion of the refusal of legislators to "cap" compensation for injured patients, followed by the statement, "Medical malpractice rates in the state have risen steadily over much of the last decade." It then proceeds to discuss one 14% rate increase in 2007, and says without subsequent rate freezes, "malpractice rates have been projected

[24] NYPIRG, *System Failure; A Review Of New York State's Doctor Discipline System*, June 2010.

to increase dramatically." If the authors are trying to link the current insurance situation in New York State with the legal system or the failure to enact "caps," they are completely out of line.

On July 2, 2007, the New York State Insurance Department announced the 14 % rate increase and established a Medical Malpractice Liability Advisory Task Force to come up with ways to resolve what was said to be a $525 million deficit faced by the Medical Malpractice Insurance Plan, an assigned risk pool for doctors with spotty malpractice track records, who, by law, were required to be covered. MMIP was the successor to another plan that had built up a surplus of close to $1 billion, but which Govs. Mario M. Cuomo and George Pataki drained to balance the state budget. Because of how MMIP was structured, the deficit had to be "shouldered by the few companies selling malpractice insurance in the state, exerting further pressure on insurance rates. None of this had anything to do with any lawsuit or a claims "crisis."

While some of us were asked to serve on this Task Force, others were not offered a seat at the table. As time went on, it became clear that the Task Force was being used by the medical lobbies, with the support of the Department of Health, to push a radical tort reform agenda. One idea, never even discussed by the task force but rather constructed by the medical and insurance lobbies behind closed doors and reported in the news, would have had Medicaid assume the burden of subsidizing malpractice in the state. Therefore, the proposal's statement, "Based on [the task force] work, legislation containing tort reform and patient safety initiatives was proposed in 2008 and 2009, but was not adopted" is utterly ridiculous. The task force stopped meeting in December 2007. There was no final meeting, no report, no proposals coming out of this work. The insurance situation is still not solved and this proposal does nothing to address it.

But the bottom line is that all the data at the time and currently confirm that there is no crisis in terms of payouts or even in increases in the premium charged in New York State. To the extent there are problems, they were of recent vintage[25] and caused by the foolish political decisions by prior Governors to drain the MMIP fund to balance the state budget. Moreover, the deficits are projected to be paid out over many future years, not immediately.

Misrepresentation: Litigation is a Bad Thing

There is no question that one of the goals of this experiment is to reduce even further the role of litigation and small number of jury trials in resolving contested disputes, which are the only cases that go to trial because most cases settle. Tort reform lobby groups have always argued that jurors cannot understand complex cases, that juries are arbitrary and emotional, and that jury trials are too cumbersome and costly. Yet virtually all reliable jury research disproves these statements.[26]

The data also shows that the threat of a jury trial provides the incentive for the vast majority of true medical malpractice cases currently to settle.

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[25] New York Department of Insurance, *The Status of the Primary and Excess Medical Malpractice Market and the Future Need for the Medical Malpractice Insurance Association* (December 1, 1997) (finds the market very competitive and prices increasing only at about inflation for the decade.)

[26] See extentive research cited in JURY VERDICTS – CONSISTENT AND CONSERVATIVE, Center for Justice & Democracy, 2010, found at http://centerjd.org/archives/issues-facts/stories/MB_2010juries.php.

- In the Harvard closed claims study, referenced above, 15 percent of claims were decided by trial verdict.[27] Other research shows that 90 percent of cases are settled without jury trial, with some estimates indicating that the figure is as high as 97 percent.[28]
- Vidmar further testified, "Without question the threat of a jury trial is what forces parties to settle cases. The presence of the jury as an ultimate arbiter provides the incentive to settle but the effects are more subtle than just negotiating around a figure. The threat causes defense lawyers and the liability insurers to focus on the acts that led to the claims of negligence.[29]

But litigation also has an incredibly important patient safety function, which will be significantly weakened by this experiment. Numerous medical practices have been made safer only after the families of sick and injured patients filed lawsuits against those responsible. These include catheter placements, drug prescriptions, hospital staffing levels, infection control, nursing home care and trauma care.[30] As a result of such lawsuits, the lives of countless other patients have been saved.

The academic literature confirms this. David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law, and Charles Silver of the University of Texas at Austin School of Law, have researched and written extensively about medical malpractice. They say, "No study has shown that liability exposure causes health care quality to decline overall. Instead, the best available evidence shows that liability makes a modest positive contribution to patient safety despite the definitive and unqualified claims to the contrary...."[31] The field of surgical anesthesia, where anesthesiologists adopted practice guidelines to reduce deaths, injuries, claims and lawsuits, is a strong case in point. Hyman and Silver write,

- "[T]wo major factors forced their hand: malpractice claims and negative publicity.… Anesthesiology [malpractice] premiums were ... among the very highest—in many areas, two to three times the average cost for all physicians. By the early 1980s, anesthesiologists recognized that something drastic had to be done if they were going to be able to continue to be insured.… Anesthesiologists worked hard to protect patients *because* of malpractice exposure, not in spite of it."[32]
- "The authors of the Harvard [Medical Practice Study] study acknowledged this themselves: '[T]he litigation system seems to protect many patients from being injured in the first place. And since prevention before the fact is generally preferable to compensation after the fact, the apparent injury prevention effect must be an important factor in the debate about the future of the malpractice litigation system.'"[33]

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[27] David M. Studdert, Michelle Mello, et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine,* May 11, 2006.

[28] Testimony of Neil Vidmar, Russell M. Robinson, II Professor of Law, Duke Law School before The Senate Committee on Health, Education, Labor and Pensions, "Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006 at 17. (citations omitted).

[29] *Ibid*. at 21.

[30] Meghan Mulligan & Emily Gottlieb, *Lifesavers: CJ&D's Guide to Lawsuits that Protect Us All,* Center for Justice & Democracy (2002), Hospital and Medical Procedures, A-36 *et seq.*, B-12 *et seq*.

[31] David A Hyman and Charles Silver, "The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?," 90 Cornell L. Rev. 893, 917 (2005).

[32] *Ibid* at 920, 921.

[33] Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 47, citing Paul C. Weiler, Joseph P. Newhouse, & Howard H. Hiatt, A Measure Of Malpractice: Medical Injury, Malpractice Litigation, And Patient Compensation 133 (1993).

- The *New England Journal of Medicine* published a recent article confirming this point: that litigation against hospitals improves the quality of care for patients, and that "more liability suits against hospitals may be necessary to motivate hospital boards to take patient safety more seriously."[34]

"As Hyman and Silver explain, the reason why tort liability promotes patient safety is obvious. As the title of their most recent article says, 'it's the incentives, stupid': Providers are rational. When injuring patients becomes more expensive than not injuring them, providers will stop injuring patients.…. In short, the notion that errors would decline if tort liability diminished is ridiculous."[35]

No one said this better than Dr. Wayne Cohen, then-medical director of the Bronx Municipal Hospital, who said, "The city was spending so much money defending obstetrics suits, they just made a decision that it would be cheaper to hire people who knew what they were doing."[36]

Misrepresentation: Medical Malpractice Litigation Drives Up Health Care Costs

The proposal states, "the growth in severity is frequently cited as a leading contributor of health care costs." As discussed above, there no real dollar severity growth in New York State.

Moreover, the Congressional Budget Office recently found that even if the country enacted the entire menu of extreme tort restrictions listed,[37] many of which New York State already has plus a severe "caps", it can go no farther than to find an extremely small percentage of health care savings, "about 0.5% or $11 billion a year at the current level -- far lower than advocates have estimated"[38] It should also be noted that CBO based its findings on a small handful of studies, several of which are noted to contradict each other. One of them suggests that 50,000 more people could die in the next ten years (beyond the 98,000 that already die annually from medical errors) should Congress further limit legal rights of patients.

In conclusion, we are not launching a general complaint about voluntary and non-binding informal ways to resolve disputes. Settlement conferences are entirely appropriate. A great many cases are successfully resolved this way already. Nor are we critiquing the current OCA intensive settlement model which exists in New York City. But this is not that. This is an anti-patient, anti-plaintiff model that will harm patients, interfere with efforts to expose unsafe medical care, and has no place in New York State or the rest of the country.

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[34] 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.

[35] Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 47, citing David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 Vand. L. Rev. 1085, 1131 (2006).

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

[37] A $250,000 cap on non-economic damages, $500 cap 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.

[38] Alexander C. Hart, "Medical malpractice reform savings would be small, report says," *Los Angeles Times,* October 10, 2009; http://www.latimes.com/news/nationworld/nation/la-na-malpractice10-2009oct10,0,4877440.story