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**Testimony of Joanne Doroshow
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Hearing on HB 377 – Maryland No-Fault Injury Fund

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Thank you for the opportunity to address these committees about the proposed Maryland No-Fault Birth Injury Fund. I am Joanne Doroshow, President and Executive Director of the Center for Justice & Democracy at New York Law School, where I am an Adjunct Professor of Law. CJ&D is a national non-profit public interest organization that is dedicated to educating the public about the importance of the civil justice system. I also co-founded Americans for Insurance Reform, a coalition of nearly 100 public interest groups that works for better oversight of the insurance industry. I served on a New York State Medical Malpractice Task Force in 2007 and 2008. And I have testified in Congress six times on medical malpractice issues.

HB 377 proposes to change how brain-injured newborns are compensated in Maryland, including children who are catastrophically injured through no fault of their own but rather as a result of negligent or reckless practices. The burden of this proposal falls entirely on them – the most seriously injured and vulnerable victims of medical malpractice. Their access to the jury system would be abolished no matter the extent of the hospital’s misconduct or the severity of the child’s injury. This proposal denies their families the same kind of rights and recourse that every other negligence victim has in the state. If an adult man is injured by medical malpractice in Maryland, he would be able to sue his doctor or hospital, receive compensation determined by a neutral judge or jury after hearing all the evidence, and obtain some measure of justice by holding the wrongdoer accountable in court. Under the current proposal, brain injured newborns and their families would be stripped of this constitutional right.

Indeed, the wholesale dismissal of the jury system, the creation of an entirely new state agency to handle what are a minuscule percentage of cases in the court system,¹ the likely costs of maintaining such a system, and the immorality of the shifting responsibility for hospital

¹ According to the National Center for State Courts, “Although medical malpractice and product liability cases often generate a great deal of attention and criticism, they comprise...less than 1% of the total civil caseload....” National Center for State Courts, *The Landscape of Civil Litigation in State Courts* (November 2015), <http://www.ncsc.org/~/media/Files/PDF/Research/CivilJusticeReport-2015.ashx>

wrongdoing onto others, is why no state has seriously considered adopting Virginia's birth injury program since its inception 30 years ago.

Before turning to the specifics of the current proposal, I want to address three overall points. First, proponents of this bill are regurgitating the same unfounded threats about "lack of access to care for women" that we have seen for years from the insurance and medical lobbies and their political allies, such as Texas politicians Rick Perry and George W. Bush. The suggestion that OB-GYNs might leave Maryland or abandon their specialty if this horrendous legislation isn't enacted is sensationalized fiction. In Texas, that realization came too late to stop legislation that stripped families of their legal rights, later leading to articles like "Baby I Lied."² Don't let this happen in Maryland. In particular, when exploring a topic as controversial as this, it is important to distinguish between unbiased academic or government studies, and "push polls" or surveys from medical associations that are conceived by hospital lobbyists or political professionals seeking to demonstrate support for their pre-defined political or legislative agenda.

As a national consumer organization that has, for years, been fighting the insurance and medical lobbies over patients' rights, we know exactly how issues of "access" tend to be discussed – couched in fear-mongering, not facts; anecdotes, not academic studies. There are years of studies showing no correlation whatsoever between where physicians decide to practice and the malpractice environment, including malpractice insurance rates and state tort law. The actual experiences of other states bear this out. If the medical groups would like to discuss anecdotes or surveys, we can certainly point the legislature to thousands of other kinds of stories – individual cases of medical negligence. These injured patients are often the forgotten faces in the debate over medical malpractice proposals written by hospital lobbies, like this one.

Which leads to my second point. For over 40 years, policy proposals in the area of medical malpractice have concentrated almost entirely on the "doctors as victims" narrative. In other words, the insurance, hospital and medical lobbies effectively turned the malpractice issue on its head, so that policymakers treat medical malpractice primarily as if doctors, hospitals 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, including in Maryland, virtually all of which are designed to weaken the liability of health care providers. This proposal is yet another example. Indeed, the medical industry already benefits from more liability protections than virtually any other industry or profession in the nation. This is part of the reason why the vast majority of preventable errors that physicians commit never result in a claim at all. That fact has been confirmed by at least two recent studies from researchers at Johns Hopkins University School of Medicine.³

² Suzanne Batchelor, "Baby, I Lied," *Texas Observer*, October 19, 2007, <http://www.texasobserver.org/2607-baby-i-lied-rural-texas-is-still-waiting-for-the-doctors-tort-reform-was-supposed-to-deliver/> ("The [Texas] campaign's promise, that tort reform would cause doctors to begin returning to the state's sparsely populated regions, has now been tested for four years. It has not proven to be true.... [D]octors are following the Willie Sutton model: They're going, understandably, where the better-paying jobs and career opportunities are, to the wealthy suburbs of Dallas and Houston, to growing places with larger, better-equipped hospitals and burgeoning medical communities.")

³ See Johns Hopkins University School of Medicine Professor of Surgery Marty Makary, M.D., M.P.H. et al., 2014 "Medical Harm: Patient Perceptions and Follow-up Actions," *Journal of Patient Safety*, November 13, 2014, http://journals.lww.com/journalpatientsafety/Abstract/publishahead/Medical_Harm__Patient_Perceptions_and_Follow_up.aspx ("The vast majority of patient harms never result in a lawsuit."); Johns Hopkins University

Finally is the irony of a central criticism made by providers and hospitals who say this system is needed in Maryland because the malpractice system delivers compensation too slowly to victims. As others have written,⁴ “This argument strikes us as an example of the ‘chutzpah defense,’ best exemplified by the individual who killed his parents, and then threw himself on the mercy of the court because he was an orphan.” Nothing today prevents hospitals or liability carriers from settling legitimate claims with patients before they file a court case, or from paying valid claims expeditiously. In fact, CJ&D and the malpractice victims with whom we work all agree that informal pre-trial settlements, where both parties voluntarily agree to take a case out of the civil justice system, are not only appropriate but currently resolve the vast majority of legitimate medical malpractice claims today. However, schemes like this – which tilt the legal playing field dramatically in favor of the health care industry, eviscerate the jury system and patients’ rights to adequate compensation, and protect the most dangerous hospitals and incompetent physicians – are deplorable.

THE MARYLAND NO-FAULT BIRTH INJURY FUND

This system would do away with the civil justice system in medical malpractice cases for brain-injured newborns, replacing it with government regulation of what is now a free-market approach to holding health care providers accountable for their negligence. This proposal envisions establishment of a centralized fund controlled by a Board of Trustees, consisting of a privileged group of political appointees pulled largely from the powerful Maryland medical establishment. This Board is given the job of controlling compensation to qualifying families and hiring bureaucrats to execute their rules. Every aspect of compensation in these cases would be controlled by this new centralized agency. We know that non-economic damages would be capped below current law at \$500,000, if provided at all. Compensation for residential modification would be disallowed.

Beyond that, we are somewhat hampered in our analysis of this bill because certain important details are not spelled out but left to the discretion of the Board, the Executive Director and the centralized staff of bureaucrats that they hire. Details that we do not know yet include: the level of economic damages that would be available; the specific burdens any family would face obtaining compensation under this fund; how much of the cost would be passed along to health insurance policyholders to maintain the fund; the level of financial windfall this measure would provide unsafe hospitals at the expense of patients whom they injure; and the amount of increased profit that the property/casualty insurance industry would enjoy once benefit levels are cut now and into the future.

School of Medicine Associate Professor of Surgery Martin Makary, M.D., M.P.H. and Johns Hopkins University School of Medicine Associate Professor of Neurology David E. Newman-Toker, M.D., Ph.D., “Measuring Diagnostic Errors in Primary Care,” *JAMA Internal Medicine*, March 25, 2013, <http://archinte.jamanetwork.com/article.aspx?articleid=1656536> (“Only about 1% of adverse events due to medical negligence result in a claim.”)

⁴ David A. Hyman and Charles Silver, “Medical Malpractice Litigation and Tort Reform: It’s the Incentives, Stupid,” 59 *Vand. L. Rev.* 1085, 1122 (2006), http://faculty.law.miami.edu/mcoombs/documents/Hyman_Silver.pdf

THE COSTS OF ALTERNATIVE SYSTEMS THAT LIMIT LIABILITY AND BRING IN NON-NEGLIGENCE CLAIMS ARE HUGE

This bill would create a vast new social program to cover all similar outcomes whether or not malpractice was involved. Many of these cases are not currently within the medical malpractice liability insurance system. Nor should they be. The fiscal problems this will create are addressed below in the discussion about Virginia's birth injury program. But to provide an additional perspective, Case Western Reserve Professors Maxwell J. Mehlman and Dale A. Nance made the following observations about a proposal with similar aspects to HB 377, specifically, an alternative system that brings currently non-claiming patients into the system:

- Health courts "would entail some huge potential increases in total system costs.... If we take health care proponents at their word, their goal is to bring ... currently non-claiming people into the process." This, however "would multiply the number of claims involving negligence by a factor between 33 and 50."⁵
- "[C]laims involving error account for at least 84 percent of total system costs ... so that, even if we assume that only claims involving error are brought into the system, the system costs should increase by a factor of at least 28, all other things (like system efficiency) being equal."⁶
- "[E]ven if we assume that the average per patient damages under a new system embracing all potential claimants (including those who claim under the existing system) would be only 30 percent of the average damages for claims now paid, that still leaves total direct system costs multiplied by a factor of about 8.5, again as a low end estimate."⁷
- Health courts all involve the creation of a new judicial or administrative bureaucracy. Costs "would certainly be substantial, vastly more than the public (taxpayer borne) judicial costs currently associated with the adjudication of malpractice claims."⁸
- "Some health court advocates concede that, if the system actually compensated substantially more patients, it might not be cheaper than the tort system. The Republican Policy Committee states, for example: 'The health court proposal is not about reducing costs overall (since many more people may be compensated at smaller amounts).'"⁹
- "[O]ther pressures can be expected as well. ...[A] number of processes can be expected to be implemented, processes that suppress the levels of patient recoveries below any fair measure of actual losses sustained."¹⁰

⁵ Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 72.

⁶ *Ibid.*

⁷ *Ibid.*

⁸ *Id.* at 73.

⁹ *Id.* at 74.

¹⁰ *Id.* at 75.

Moreover, studies show that when a state strips away a patient's right to sue in court, health care costs not only do not drop – they *increase* as the deterrence function of the tort system is weakened leading to the practice of riskier medicine. This was the alarming recent conclusion from esteemed, longtime academics in the field of medical malpractice, who examined the impact on costs of laws that limit liability exposure, specifically “caps” on damages. They found that such laws “have no significant impact on Medicare Part A (hospital) spending, but lead to 4-5% *higher* Medicare Part B (physician) spending” [emphasis in the original]. The researchers say,

[O]ne policy conclusion is straightforward: There is no evidence that limiting medical lawsuits will bend the healthcare cost curve, except perhaps in the wrong direction.

Policymakers seeking a way to address rising healthcare spending should look elsewhere.¹¹

ALTERNATIVE SYSTEMS HAVE SYSTEMIC AND CONSTITUTIONAL PROBLEMS

Every state in the nation, including Maryland, guarantees the right to trial by jury in civil cases.¹² When a legislature strips away that right and removes a common law cause of action from the civil justice system, the courts insist that those ceding their rights receive something sufficient in return, an adequate “quid pro quo,” or trade-off, for losing constitutional rights.¹³ Here, the promise is that a no-fault system will award some compensation and do it more quickly. Yet it also prevents patients from obtaining the same level of compensation that is available to those with access to the jury system. What’s more, even if a program begins with good intentions, taking any compensation decision out of courts subjects it eventually to influence-peddling and future budgetary/solvency considerations that no lawmaker today can control. These problems are always resolved on the backs of more powerless victims, who gave up their legal rights with vague and unenforceable promises that are ultimately broken. That is the lesson of history, and it is why HB 377 raises such significant constitutional concern.

Indeed, it is important to immediately dispose of the notion that under this no-fault fund, there will not be a reduction in benefits for children whose injury was the result of negligence or

¹¹ Bernard S. Black, David A. Hyman and Myungho Paik, “Do Doctors Practice Defensive Medicine, Revisited,” Northwestern University Law & Economics Research Paper No. 13-20; Illinois Program in Law, Behavior and Social Science Paper No. LBSS14-21 (October 2014) at 2, <http://ssrn.com/abstract=2110656>. See also Jason Milliman, “Study: Don’t expect big health-care savings from medical malpractice reform,” *Washington Post*, October 15, 2014, <https://www.washingtonpost.com/news/wonk/wp/2014/10/15/study-dont-expect-big-health-care-savings-from-medical-malpractice-reform/>; RAND Corporation, “Making It More Difficult to Sue Physicians for Malpractice May Not Reduce ‘Defensive Medicine,’ ” October 15, 2014, <http://www.rand.org/news/press/2014/10/15.html>, discussing Daniel A. Waxman et al., “The Effect of Malpractice Reform on Emergency Department Care,” 371 N. Engl. J. Med. 1518, October 16, 2014, <http://www.nejm.org/doi/full/10.1056/NEJMsa1313308>

¹² Colorado and Louisiana do not have such provisions in their constitutions but have statutory provisions.

¹³ See, e.g., Amy Widman, “Why Health Courts are Unconstitutional,” 27 *Pace L. Rev.* 55 (Fall 2006), <http://digitalcommons.pace.edu/cgi/viewcontent.cgi?article=1118&context=plr>

wrongdoing. We can say this with complete confidence even without knowing all the details of the plan under consideration. In fact, we would venture to say that never in the history of this country has an administrative system turned out ultimately better for victims who ceded their right to trial by jury.

There are many examples of this phenomenon, including workers' compensation,¹⁴ whose fiscal problems are typically solved by reducing benefits and increasing obstacles for workers, and the federal Vaccine Injury Compensation Program, which tries to reduce costs by fighting parents who try to get in the system.¹⁵ These programs' slow political capture, fiscal problems and subsequent demise as adequate alternatives for victims should serve as a loud warning to Maryland lawmakers.

No example is more analogous than Virginia's Birth-Related Neurological Injury Compensation Program, which has been in place for 30 years. Except for Florida's radically different program enacted one year later, no state has attempted to replicate Virginia's disastrous program. In testimony before the Virginia legislature, one parent called this program "a generous system of care gone awry, of state-sanctioned impunity for doctors and hospitals, and of the struggle families face caring for society's weakest children."¹⁶

¹⁴ See Michael Grabell and Howard Berkes, "The Demolition of Workers' Comp; Over the past decade, states have slashed workers' compensation benefits, denying injured workers help when they need it most and shifting the costs of workplace accidents to taxpayers," *ProPublica* and *NPR*, March 4, 2015, <https://www.propublica.org/article/the-demolition-of-workers-compensation>; "Worker's Comp: Falling Down on the Job," *Consumer Reports* (2000)(discussing legislative reforms of the 1990s and the resulting profits for workers' compensation insurance providers), <http://www.injuredworker.org/forums/injuredworker/posts/1652.html>; Martha T. McCluskey, "The Illusion of Efficiency in Workers' Compensation 'Reform,'" 50 *Rutgers L. Rev.* 657, 699-700, 711 (citations omitted)(Spring 1998), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=139583. In sum, having ceded their right to jury trial at a time when the law would have left most of their injuries uncompensated, these workers now face serious disadvantages relative to those with access to the judicial system. See Center for Justice & Democracy, *Workers' Compensation – A Cautionary Tale* (2006), <https://centerjd.org/content/workers-compensation-cautionary-tale-national>

¹⁵ The Vaccine Injury Compensation Program was created by federal statute in the mid-1980s. National Childhood Vaccine Injury Act of 1986, P.L. 99-660. As originally contemplated, if you or your child receives a covered vaccine and then presents a covered injury from the vaccine, you or your child is entitled to compensation. However, as this law's implementation has been modified by new political forces, extreme problems with access and compensation for victims have developed. Although originally proposed as a no-fault model that would be efficient and provide for quick compensation, many experts say that the program has been co-opted by political forces and turned into a victim's nightmare. See Elizabeth C. Scott, "The National Childhood Vaccine Injury Act Turns Fifteen," 56 *Food & Drug L.J.* 351 (2001)(stating that, as of 2001, 75 percent of claims were denied after long and contentious legal battles taking an average of 7 years to resolve). See also Statement of the National Vaccine Information Center Co-Founder and President Barbara Loe Fisher before U.S. House Subcommittee on Criminal Justice, Drug Policy and Human Resources, "Compensating Vaccine Injury: Are Reforms Needed?" September 28, 1999 (discussing the unilateral power HHS has to change the burdens of proof and other restrictions), <http://www.nvic.org/nvic-archives/testimony/congresstestimonysept281999.aspx>; Derry Ridgway, "No-Fault Vaccine Insurance: Lessons from the National Vaccine Injury Compensation Program," 24 *J. Health Pol'y & L.* 59, 69 (1999)(describing how the program originally awarded many more claims, until the Department of Justice decided to aggressively argue against claimants).

¹⁶ Bill McKelway, "Danville Has High Birth-Injury Rate; Critics Say Virginia Law Shields Doctors from Lawsuits," *News Virginian*, June 1, 2003.

The Virginia program was established in the mid-1980s, during this country's second so-called "insurance liability crisis." It was enacted not as a liberal social program, but rather under an extortionate threat by insurance companies. The state's main insurance provider stopped providing obstetrical insurance. When asked what would be needed to make them provide insurance again, the provider responded that "if the legislature passes legislation which takes the 'birth-related neurological injury' out of the tort system, we will lift the moratorium."¹⁷

Like HB 377, the program was set up as an injury compensation system for catastrophically injured newborns. It is the exclusive remedy for children delivered by participating OB-GYNs and hospitals. All claims go before an administrative panel, established within the workers' compensation system. The panel is "aided" by an "expert" panel of three doctors who determine if the injury is a covered birth-related neurological injury.

This program has struggled on every level. In 2002, Virginia's Joint Legislative Audit and Review Commission suggested "abandoning or overhauling" the program¹⁸ and "ridding the board of its heavy presence of medical professionals,"¹⁹ and found that the program could not be made fiscally sound.²⁰ Indeed, the program is often in fiscal crisis. This is so even though the child's non-economic damages are not simply capped – but entirely eliminated. The fund has been close to \$130 million short of cash and the legislature decided to fix the problem on the backs of the victims and their families even further, in complete contradiction to the law's original intent, *i.e.*, "by giving up their right to bring suit, families were promised lifelong medical care for eligible children."²¹ As reported in the *Richmond Times-Dispatch*, "documents obtained by *The Times-Dispatch* show that the [legislative] plan would erase as much as half the shortage, about \$70.3 million, by capping benefit payments to children and through accounting adjustments that lessen cash obligations by some \$44 million."²² Today, it is operating at a deficit of approximately \$56,557,000.²³

The following are some of the more notable problems for families:

- **Prevents patients from receiving adequate compensation and understanding the medical errors and negligence responsible:** "Children born in Virginia with catastrophic neurological injuries are promised lifetime medical care by the birth-injury program. But these children and their families also have been forced to absorb stunning

¹⁷ See David G. Duff, "Compensation for Neurologically Impaired Infants: Medical No-Fault in Virginia," 27 *Harv. J. on Legis.* 391, 405-407, fn. 110 (1990)(citing January 13, 1987 letter from Gordon D. McLean, Executive Vice-President, The Virginia Insurance Reciprocal to Ronald K. Davis, Virginia Surgical Associates, chairman of MSV's Professional Liability Committee)(on file at *Harv. J. on Legis.*).

¹⁸ Bill McKelway, "Study Faults Program for Brain-Injured; Shortcomings Found in Care for Children," *Richmond Times Dispatch*, November 13, 2002; Liz Szabo and Elizabeth Simpson, "Birth Injuries Get 'Minimal Review; State Report Says Board Must Hold Doctors Accountable,'" *Virginian-Pilot*, November 15, 2002.

¹⁹ Bill McKelway, "Brain-Injury Program's Outlook Dim; Cost Savings for Doctors Meant Less for Children," *Richmond Times-Dispatch*, November 16, 2002.

²⁰ *Ibid.*

²¹ Bill McKelway, "Plan could restore financial soundness," *Richmond Times-Dispatch*, September 17, 2007.

²² *Ibid.*

²³ *Virginia Birth-Related Injury Compensation Fund: Comprehensive Annual Financial Report for the fiscal year ended December 31, 2014*, June 11, 2015, <http://www.vabirthinjury.com/wp-content/uploads/2015/07/2014-Vabirth-audit-Final.pdf>

disparities in program benefits because of shifting priorities and cost reductions over which they had no control or voice. . . . ‘The program can end up providing very little,’ said Christina Rigney, referring to the minimal benefits her family received in the face of her son’s traumatic birth and brief life. ‘We believed there was negligence involved, but nothing ever came of it.’” Her son died three years after he was severely injured due to oxygen loss during birth. Because of the birth injury law, the family couldn’t file a malpractice suit, the obstetrician was never even asked to explain what happened, and the family could learn nothing from illegible notes that failed to account for long periods of time. Families of two other brain-injured infants he delivered faced the same limits on their ability to learn what happened, or to show he was negligent. He faced a lawsuit, however, for a fourth case in which a woman giving birth bled to death after delivering a healthy baby.²⁴ (See below on how this program shields bad doctors.)

- **Cannot adjust to new medical research:** The program has been unable to adjust to current medical understanding because definitions of which injuries are covered have not changed in 15 years, despite important advances in understanding the causes of brain damage in babies. The program has rejected claims because it used outdated criteria for assessing birth injuries. “Decisions in the [Virginia program’s] cases can mean the difference between a lifetime care for some of society’s most-disabled children and no guarantees that medical expenses will be covered. Many families have had to opt for institutionalizing their children.”²⁵
- **Denies any compensation to families of infants who died minutes after birth:** Until recently, the program provided for lifetime care but nothing for wrongful death (a new provision to provide up to \$100,000 to deceased children went into effect in July 2003). This led to perverse situations such as a case where the obstetrician and hospital successfully argued before the administrative body that an infant who lived only minutes qualified for the program, protecting them from any liability other than the care provided during the deceased infant’s 30-minute lifetime.²⁶

PATIENT SAFETY WILL SUFFER

Medical errors are the third leading cause of death in America,²⁷ and some of the most horrifying studies of malpractice come not from my state, New York, but from the Johns Hopkins

²⁴ Bill McKelway, “Danville Has High Birth-Injury Rate; Critics Say Virginia Law Shields Doctors from Lawsuits,” *News Virginian*, June 1, 2003.

²⁵ Bill McKelway, “Old Rules Deny New Benefits; Children Rejected for Brain-Injury Program,” *Richmond Times-Dispatch*, June 5, 2003.

²⁶ Bill McKelway, “Deceased Infant Put into Program; Ruling Blocks Suits Over Death of Baby,” *Richmond Times-Dispatch*, June 27, 2003.

²⁷ According to a study published in the *Journal of Patient Safety*, “between 210,000 and 440,000 patients each year who go to the hospital for care suffer some type of preventable harm that contributes to their death, the study says. That would make medical errors the third-leading cause of death in America, behind heart disease, which is the first, and cancer, which is second.” Marshall Allen, “How Many Die From Medical Mistakes in U.S. Hospitals?” *ProPublica*, September 19, 2013, <http://www.propublica.org/article/how-many-die-from-medical-mistakes-in-us-hospitals>, discussing John T. James, “A New, Evidence-based Estimate of Patient Harms Associated with Hospital

University School of Medicine. One recent study, led by Johns Hopkins and 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. Six percent of these patients die. Another 32.9% have permanent injuries.²⁸ 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.”²⁹

One of the worst aspects of Virginia’s program – which has been included in the Maryland proposal – is that it fails to hold accountable even the worst practitioners and allows them to continue practicing. National birth-injury experts have expressed fear about Virginia becoming a safe harbor for bad doctors because of a lack of disciplinary actions under this law. “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.”³⁰ In fact, by at least 2002 when the media was examining the fund, not a single case in the program’s history had 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.”³¹

No state can risk such a development, including Maryland. If state medical boards did their job and worked to weed out the small number of doctors responsible for most malpractice payments, everyone would win. But they don’t, they never have, and it is fantasy to expect that they ever will. Just this month, the *New England Journal of Medicine* published a new study³² finding that “[j]ust 1 percent of active U.S. physicians are responsible for nearly a third of the nation’s paid malpractice claims....” Moreover “[n]eurosurgeons, orthopedic surgeons, general surgeons and obstetrician-gynecologists were among those who faced double the risk of future claims,

Care,” *Patient Safety* (September 2013), <https://www.documentcloud.org/documents/781687-john-james-a-new-evidence-based-estimate-of.html#document/p1/a117333>

²⁸ See Johns Hopkins Medicine press release, “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, discussing Marie Diener-West et al., “Surgical never events in the United States,” *Surgery*, December 18, 2012, [http://www.surgjournal.com/article/S0039-6060\(12\)00623-X/abstract](http://www.surgjournal.com/article/S0039-6060(12)00623-X/abstract)

²⁹ 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.bmjjournals.com/content/early/2012/07/23/bmjq-2012-000803.abstract>

³⁰ Bill McKelway, “Brain Injuries Spur No Action; Case Review, Required by Law, Is Not Being Done, Va. Study Found,” *Richmond Times-Dispatch*, January 14, 2003.

³¹ Bill McKelway, “Brain-Injury Program’s Outlook Dim; Cost Savings for Doctors Meant Less for Children,” *Richmond Times-Dispatch*, November 16, 2002.

³² Karen Pallarito, “Small Number of Doctors Trigger Big Share of Malpractice Payouts,” *HealthDay*, January 27, 2016, <http://consumer.healthday.com/public-health-information-30/legal-health-news-758/just-a-few-doctors-trigger-large-share-of-malpractice-payouts-707473.html>, discussing David M. Studdert, L.L.B., Sc.D. et al., “Prevalence and Characteristics of Physicians Prone to Malpractice Claims.” 374 N. Engl. J. Med. 354 (2016),

compared with internal medicine physicians....” But the study found that a physician’s specialty or even the nature of the injuries they cause, is not “the most important predictor of a claim.”

Instead,

The most important predictor of a claim appeared to be a physician’s past claims history. Compared with doctors with one previous paid claim, those with two paid claims had almost twice the risk of having another. Physicians with three paid claims had three times the risk. Those with six or more had more than 12 times the risk, the study found.

Lead author David Studdert, Professor of Medicine and Law at Stanford University, said, “It is a very reasonable question to ask why it’s possible to accumulate four or five paid claims in a 10-year period and continue to practice [medicine].... We don’t know the answer to that question.”³³

Of course, we do know. State medical boards generally do nothing about the small number of doctors who are repeat offenders and are responsible for the large chunk of negligence in the system. And Maryland’s history should be of concern to all lawmakers in this state. In 2004, the last time Public Citizen examined Maryland, they found:³⁴

Doctors with repeated malpractice claims against them suffer few consequences. The Maryland Board of Physician Quality Assurance and the state’s health care providers have been criticized in the media and by lawmakers for failing to rein in doctors who repeatedly commit medical errors and medical negligence. According to Public Citizen’s analysis of NPDB data, only 20.6 percent (37 of 180) of Maryland doctors who made three or more malpractice payouts since 1990 were disciplined by the Board. Disciplinary action is a license suspension or revocation, or a limit on clinical privileges.

The Maryland Board of Physician Quality Assurance has been among the nation’s least diligent when it comes to disciplining doctors. In 2002, Maryland ranked 46th among all states and the District of Columbia for the frequency at which it takes serious disciplinary actions against doctors for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses or other offenses. In 2002, the Board levied serious sanctions against only 39 of its 21,833 doctors. Nationally in 2002, there were 3.6 serious actions taken for every 1,000 physicians. The rate was exactly half that in Maryland – only 1.8 serious actions per 1,000 physicians. Over the past decade, Maryland has descended sharply in its rate of doctor discipline, from its best ranking of 19th in 1993 to its worst ranking of 46th in 2002. In seven of the last 10 years, Maryland has been rated in the bottom half of all states.

When regulation fails, as is clearly has in Maryland, litigation becomes the last line of defense to protect patients. And with the amount of malpractice in hospitals growing at alarming rates, the

³³ Karen Pallarito, “Small Number of Doctors Trigger Big Share of Malpractice Payouts,” *HealthDay*, January 27, 2016, http://consumer.healthday.com/public-health-information_30/legal-health-news-758/just-a-few-doctors-trigger-large-share-of-malpractice-payouts-707473.html

³⁴ Public Citizen, *The Facts About Medical Malpractice in Maryland* (January 2004), http://www.citizen.org/documents/Maryland_MedMal_Report_2004.pdf

last thing Maryland lawmakers should do is reduce the accountability of negligent doctors and hospitals. Yet under this proposal, that is exactly what would happen: unsafe hospitals would no longer pay for their own incidents of negligence and others would share the costs. As the late Cornell Law School Professor Theodore Eisenberg, “one of the foremost authorities on the use of empirical analysis in legal scholarship,”³⁵ noted in a recent article, “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. ...and [h]ospitals do not bear the full costs of the harms caused in them even though hospitals directly and indirectly influence patients’ risk of medical error.”³⁶

In other words, further weakening the system’s deterrent potential will only lead to more unsafe care. And that result was the clear, recent conclusion by some of the leading academic medical malpractice researchers in the nation.³⁷ They discovered “consistent evidence that patient safety generally falls” after liability for health care providers is limited [and] “leads to higher rates of preventable adverse patient safety events in hospitals.” In addition, the decline in patient safety was “widespread, and applies both to aspects of care that are relatively likely to lead to a malpractice suit (e.g., ... foreign body left in during surgery), and aspects that are unlikely to do so (e.g., ... central-line associated bloodstream infection).” In sum, “[t]he broad relaxation of care suggests that med mal liability provides ‘general deterrence’ – an incentive to be careful in general – in addition to any ‘specific deterrence’ it may provide for particular actions....”

THE “ACCESS TO CARE” MYTH

Where doctors choose to practice and live has no connection to a state’s tort law. That has been the finding of every credible academic and government study examining this issue. Aside from the fact that Maryland currently has more OB-GYNs per capita (female population) than nearly any other state,³⁸ the suggestion that OB-GYNs might leave Maryland or abandon their specialty if this law were not enacted has no support in the academic literature, government studies or actual experiences of other states.

Some of the leading academic researchers in the area of medical malpractice recently examined physician supply in nine states that limited provider liability, specifically by capping damages during the last “hard” insurance market (2002 to 2005), and compared these data to other “control” states.³⁹ They found “no evidence that cap adoption predicts an increase in total patient

³⁵ Cornell University Law School, “Ted Eisenberg: Interview,” <http://courses2.cit.cornell.edu/sociallaw/videos/eisenberg/index.html> (viewed February 11, 2016).

³⁶ Theodore Eisenberg, “The Empirical Effects of Tort Reform,” April 1, 2012. *Research Handbook on the Economics of Torts*, forthcoming, found at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2032740 (citation omitted).

³⁷ Bernard S. Black and Zenon Zabinski, “The Deterrent Effect of Tort Law: Evidence from Medical Malpractice Reform,” Northwestern University Law & Economics Research Paper No. 13-09 (July 2014), <https://business.illinois.edu/nmiller/mhec/Zabinski.pdf>

³⁸ CQ Press, *Health Care State Rankings*.

³⁹ Bernard S. Black, David A. Hyman and Myungho Paik, “Does Medical Malpractice Reform Increase Physician Supply? Evidence from the Third Reform Wave,” Northwestern University Law & Economics Research Paper No. 14-11; University of Illinois Program in Law, Behavior and Social Science Research Paper No. LBSS 14-36 (July

care physicians, in specialties that face high med mal risk (except plastic surgeons), or in rural physicians.” They concluded, “Physician supply does not seem elastic to med mal risk. Thus, the states that want to attract more physicians should look elsewhere.”

This is only the latest in a series of studies showing no connection between “access to care” and a state’s malpractice environment. As a result, “access to care” arguments tend to be discussed in hyped-up fear-mongering terms, not facts. “Who Will Deliver Your Baby?” was the headline of a glossy 2003 Texas brochure, with medical societies arguing that the only way to solve doctor shortages in Texas was for patients to enact a damages cap, which voters proceeded to do. But as has been repeatedly shown since the *Texas Observer* first pointed it out in 2007 in the article “Baby, I Lied,”⁴⁰ not only did doctors not return to the state’s underserved areas after the cap was enacted, they never came back to the state at all.

Physician supply in Texas has been closely studied by Professors Bernard S. Black, Northwestern University School of Law, Northwestern University Kellogg School of Management and the European Corporate Governance Institute (ECGI); David A. Hyman, University of Illinois College of Law; and Charles Silver, University of Texas School of Law. In their most recent Texas study,⁴¹ they found that enactment of liability limits has no effect on the state’s physician supply.⁴² The methodology for this study, which controls for every conceivable factor, is so accurate that a national “tort reform” proponent admitted changing his mind about the issue after examining their analysis.⁴³

Like Black, Hyman and Silver’s work in Texas, there are years of studies showing no correlation between where physicians decide to practice and the malpractice environment, including malpractice insurance rates. In his 2012 academic study, “The empirical effects of tort reform,” the late Cornell Law School Professor Theodore Eisenberg noted:⁴⁴

If increasing premiums drive exit decisions, then programs alleviating premiums should have effects. But Smits et al. (2009) surveyed all obstetrical care providers in Oregon in 2002 and 2006. Cost of malpractice premiums was the most frequently cited reason for stopping maternity care. An Oregon subsidy program for rural physicians pays 80 percent of the professional liability premium for an ob/gyn and 60 percent of the

2014), <http://ssrn.com/abstract=2470370>. Florida, Georgia, Illinois, Mississippi, Nevada, Ohio, Oklahoma, South Carolina and Texas were the nine states examined.

⁴⁰ Suzanne Batchelor, “Baby, I Lied.” *Texas Observer*, October 19, 2007, <http://www.texasobserver.org/2607-baby-i-lied-rural-texas-is-still-waiting-for-the-doctors-tort-reform-was-supposed-to-deliver/>

⁴¹ Bernard Black, David Hyman, Charles Silver, “Black, Silver, Hyman: Tort reform not the tonic it’s touted to be,” *Austin American-Statesman*, April 9, 2013, <http://www.statesman.com/news/news/opinion/black-silver-hyman-tort-reform-not-the-tonic-its-t/nXG9J>

⁴² David A. Hyman et al., “Does Tort Reform Affect Physician Supply? Evidence from Texas,” Northwestern University Law School, Law and Economics Research Paper No. 12-11; University of Illinois, Program in Law, Behavior and Social Science Research Paper No. LE12-12; University of Texas Law School, Law and Economics Research Paper No. 225 (June 2012) at 8, <http://ssrn.com/abstract=2047433>

⁴³ See Manhattan Institute’s Ted Frank, “Post-tort-reform Texas doctor supply,” *PointofLaw.com*, May 4, 2012, <http://www.pointoflaw.com/archives/2012/05/post-tort-reform-texas-doctor-supply.php> (“I, for one, am going to stop claiming that Texas tort reform increased doctor supply without better data demonstrating that.”)

⁴⁴ Theodore Eisenberg, “The Empirical Effects of Tort Reform,” April 1, 2012. *Research Handbook on the Economics of Torts*, forthcoming, found at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2032740

premium for a family or general practitioner. Receiving a malpractice subsidy was not associated with continuing maternity services by rural physicians. Subsidized physicians were as likely as nonsubsidized physicians to report plans to stop providing maternity care services. And physician concerns in Oregon should be interpreted in light of the NCSC finding, described above, that this was a period of substantial decline of Oregon medical malpractice lawsuit filings.

Other studies reject the notion that there is any connection between access to care and malpractice insurance rates.⁴⁵ In August 2004, the National Bureau of Economic Research researchers found: “The fact that we see very little evidence of widespread physician exodus or dramatic increases in the use of defensive medicine in response to increases in state malpractice premiums places the more dire predictions of malpractice alarmists in doubt. The arguments that state tort reforms will avert local physician shortages or lead to greater efficiencies in care are not supported by our findings.”⁴⁶

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

[L]ooked at the behavior of physicians in ‘high-risk’ specialties – practice areas such as obstetrics/gynecology and cardiology for which malpractice premiums tend to be relatively high – over the years from 1993 through 2002. They found that contrary to predictions based on the findings of earlier physician surveys, only a small percentage of these high-risk specialists reduced their scope of practice (for example, by eliminating high-risk procedures) in the crisis period, 1999-2002, when malpractice insurance premiums rose sharply.... What’s more, the proportion of high-risk specialists who restricted their practices during the crisis period was not statistically different from the proportion that did so during 1993-1998, before premiums spiked. ‘It doesn’t appear that the restrictions we did observe after 1999 were a reaction to the change in the malpractice environment,’ said Mello, the C. Boyden Gray Professor of Health Policy and Law at the Harvard School of Public Health.”⁴⁷

Finally, in 2007, I was a member of the New York Governor’s Task Force examining medical malpractice issues. The state medical society and specialty groups, like the American College of Obstetricians and Gynecologists (ACOG), were lobbying heavily for liability limits. It became clear that ACOG was making untrue statements about doctor shortages in New York State, which were similar to falsehoods conveyed to Texas residents four years prior, and continue to be false in New York. The Center for Health Workforce, part of the School of Public Health, University at Albany, State University of New York – an academic institution that monitors physician supply – testified before the Task Force on October 15, 2007. The Center found that

⁴⁵ Since 2006, the nation has been in a “soft” insurance market, with rates stable and dropping in every state whether or not “tort reforms” or a “cap” have been enacted.

⁴⁶ Katherine Baicker and Amitabh Chandra, “The Effect of Malpractice Liability on the Delivery of Health Care,” *NBER Working Paper Series* (August 2004), <http://www.dartmouth.edu/~kbaicker/BaickerChandraMedMal.pdf>

⁴⁷ “Malpractice Premium Spike In Pennsylvania Did Not Decrease Physician Supply,” *Health Affairs*, April 24, 2007, <http://www.healthaffairs.org/press/marapr0707.htm>

the number of OB-GYNs in New York State had been stable for the prior decade and between 2005 and 2006, the number of physicians doing obstetrics *increased* – all while birth rates were dropping in New York State.⁴⁸

While OB-GYN supply is not declining in New York, some physicians do leave New York and every other state; however, the reasons have nothing to do with malpractice. The main reasons physicians leave are: proximity to family; inadequate salary; and visa issues. For non-primary care physicians in New York, for example, no more than three percent leave due to the cost of malpractice insurance – practically dead last on the list of possible reasons for leaving New York State, which has some of the highest malpractice rates in the nation.⁴⁹

Physician shortages correlate with stagnating local economies and decreasing populations in those regions, not with lawsuits or insurance rates. Black, Hyman and Silver said, “Physician supply appears to be primarily driven by factors other than liability risk, including population trends, location of the physician’s residency, job opportunities within the physician’s specialty, lifestyle choices, and demand for medical services, including the extent to which the population is insured.”⁵⁰ *Reuters* summarized this issue this way: “physicians, the data shows, gravitate towards affluent locales in the United States that already have all the medical help they need.”⁵¹

The argument is also sometimes made that the malpractice environment drives doctors out of certain high-risk specialties. But as with choice of location, lifestyle considerations are far more important in determining a physician’s choice of specialty. As reported in the *New York Times*,⁵²

Today’s medical residents, half of them women, are choosing specialties with what experts call a “controllable lifestyle.”... What young doctors say they want is that “when they finish their shift, they don’t carry a beeper; they’re done,” said Dr. Gregory W. Rutecki, chairman of medical education at Evanston Northwestern Healthcare, a community hospital affiliated with the Feinberg School of Medicine at Northwestern University.... Lifestyle considerations accounted for 55 percent of a doctor’s choice of specialty in 2002, according to a paper in the Journal of the American Medical Association in September by Dr. [Gregory W.] Rutecki and two co-authors. That factor far outweighs income, which accounted for only 9 percent of the weight prospective residents gave in selecting a specialty.”

⁴⁸ Center for Health Workforce Studies, SUNY Albany School of Public Health, *Annual New York Physician Workforce Profile, 2006 and 2007 Editions*.

⁴⁹ Center for Health Workforce Studies, SUNY Albany School of Public Health, “Resident Exit Survey Summary Brief: Why Do New Physicians Leave New York and How Do They Find Their Jobs?” (December 2007), <http://chws.albany.edu/archive/uploads/2012/07/exitleavingny2007.pdf>

⁵⁰ David A. Hyman et al., “Does Tort Reform Affect Physician Supply? Evidence from Texas,” Northwestern University Law School, Law and Economics Research Paper No. 12-11; University of Illinois, Program in Law, Behavior and Social Science Research Paper No. LE12-12; University of Texas Law School, Law and Economics Research Paper No. 225 (June 2012) at 8, <http://ssrn.com/abstract=2047433>

⁵¹ Chris Baltimore, “Special Report: Are doctors what ails healthcare?” *Reuters*, November 6, 2009, <http://www.reuters.com/article/uk-usa-healthcare-doctors-idUKTRE5A524720091106>

⁵² Matt Richtel, “Young Doctors and Wish Lists: No Weekend Calls, No Beepers,” *New York Times*, January 7, 2004, <http://www.nytimes.com/2004/01/07/us/young-doctors-and-wish-lists-no-weekend-calls-no-beepers.html>

For example, compared to dermatology, which is becoming a more competitive specialty, “The surgery lifestyle is so much worse,” Dr. [Jennifer C.] Boldrick, who rejected a career in plastic surgery, told the *NYT*. “I want to have a family. And when you work 80 or 90 hours a week, you can’t even take care of yourself.”

DECREASING ERRORS IS THE ONLY FAIR AND SENSIBLE WAY TO REDUCE OBSTETRICAL CLAIMS AND LAWSUITS

When I served on a New York State medical malpractice task force in 2007 and 2008, we discussed ways to improve patient safety since that is the best way – and only fair way – to reduce injuries, claims, lawsuits and costs to the system. The presentation by Dr. Ronald Marcus, Director of Clinical Operations, Department of Ob-Gyn at Beth Israel Deaconess Medical Center, and Assistant Professor at Harvard Medical School, was instructive. It not only acknowledged the extent of birth injuries caused by OB error, but discussed the reasons for this and proven methods to correct the situation.

Dr. Marcus specifically discussed the concept of team training or crew resource management that was developed by NASA to deal with pilot error. Dr. Marcus found that with crisis management training in OB emergencies, patient outcomes dramatically improved, with a 50 percent decrease in low Apgars and neonatal encephalopathy. With crew resource management in place, he has seen a 23 percent decrease in frequency and 13 percent decrease in severity of adverse events, and a 50 percent decrease in OB malpractice cases. It should be noted that if medical errors were not the cause of certain birth-related injuries, as some doctors insist, clearly these kinds of statistics would not exist.⁵³

Similarly, 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 2002.⁵⁴ This program initially came at the recommendation of the hospital’s insurance carrier, MCIC Vermont. The authors wrote, “Our experience supports the recommendation that: ‘. . . Malpractice loss is best avoided by reduction in adverse outcomes and the development of unambiguous practice guidelines.’” Specifically, they say:

After an external review of our obstetric service, we undertook comprehensive system changes beginning in 2003, to improve patient safety on our service. Among these

⁵³ See also 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, <https://www.gpo.gov/fdsys/pkg/CHRG-109shrg28417/html/CHRG-109shrg28417.htm> (“An earlier study by Rosenblatt and Hurst examined 54 obstetric malpractice claims for negligence. For cases in which settlement payments were made there was general consensus among insurance company staff, medical experts and defense attorneys that some lapse in the standard of care had occurred. No payments were made in the cases in which these various reviewers decided there was no lapse in the standard of care.”)

⁵⁴ Amos Grunbaum, MD, Frank Chervenak, MD and Daniel Skupski, MD, “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>

patient safety changes were significant eliminations in practice variations as well as significant improvements in communication methods between staff. The main goal of these changes was to improve patient safety and decrease adverse outcomes.

For example, they used team training and other methods to improve communication, 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.

They found that “implementing a comprehensive obstetric patient safety program not only decreases severe adverse outcomes but can also have an immediate impact on compensation payments.” For example, “[t]he 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.”

CONCLUSION

Over the years, mostly under pressure from hospitals and insurers, states have occasionally considered proposals that require or push wrongly injured persons to have their disputes resolved outside the court system and/or force them to obtain compensation from an administrative system. It would be one thing if any of these systems succeeded and could be considered appropriate models for HB 377. But none has. This is due not to poor legislative construction or elements that can be fixed. Rather, it is because of one inherent flaw that infects all such systems; namely, once an area of law is removed from the civil justice system and is codified by statute, it is immediately and forever vulnerable to manipulation by political forces and fiscal concerns, and turns into a nightmare for those it was originally meant to help.

We are very much in favor of guarantees of health insurance coverage to help anyone in need of medical care. However, the provision of such medical care should never be accomplished by taking away the right to trial by jury for someone who was injured through no fault of their own, or reducing the accountability of anyone who commits wrongdoing, which will only lead to less safe medical care. HB 377 is terrible policy and should be rejected.