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Statement of Joanne Doroshow
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Before the Boston Bar Association
McDermott, Will & Emery Conference Center (28 State Street, 34th Floor)
November 19, 2003

I appreciate the opportunity to address the Boston Bar Association on the Governor's proposal to establish an "Avoidability-Based Administrative Compensation Scheme for Obstetrical Injury" in the state of Massachusetts.

The Center for Justice & Democracy (CJ&D) is a national consumer rights organization dedicated to educating the public about the importance of the civil justice system. Americans for Insurance Reform, a project of CJ&D, is a coalition of over 100 consumer and public interest groups representing more than 50 million people. Among our members are MassPIRG and the New England Patients' Rights Group. We have also worked closely with Massachusetts residents who have been the victims of medical malpractice, including John McCormack who lost his 13-month-old daughter Taylor while she was awaiting surgery to repair a malfunctioning shunt in her skull.

AIR advocates strengthening state oversight of insurance industry practices instead of trying to solve insurance problems on the backs on injured patients. Increased insurance regulation is the only real solution to ending the periodic insurance "crises" that hit this country ever 10 years or so and inevitably lead to frenetic calls for legislative limits on patients' rights to sue. The proposal before you today is simply one more variation of this recurring pattern.

I would like to address both the premise of this proposal and its merits as articulated in the outline presented to us.

A PHONY PREMISE – A BOGUS "CRISIS"

Since the premise behind this proposal is to avoid an impending medical malpractice insurance "crisis" in Massachusetts, it is critical to understand why insurance rates are skyrocketing for some doctors in some states.

The Insurance Cycle, Not the Legal System, is Driving Up Rates

Insurers make most of their money from investment income. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium

dollars to invest for maximum return. Insurers severely underprice their policies and insure very poor risks just to get premium dollars to invest. This is known as the "soft" insurance market.

But when investment income decreases — because interest rates drop or the stock market plummets or the cumulative price cuts make profits become unbearably low — the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market usually degenerating into a "liability insurance crisis."

A hard insurance market occurred in the mid-1970s, precipitating rate hikes and coverage cutbacks, particularly with medical malpractice insurance and product liability insurance. A more severe crisis took place in the mid-1980s, when most liability insurance was impacted. At that time, numerous studies, including those conducted by the National Association of Attorneys General under the direction of the Massachusetts Attorney General[1] and state commissions in New Mexico, Michigan and Pennsylvania[2], confirmed that the crisis was not caused by the legal system but rather by the insurance cycle and mismanaged underwriting by the insurance industry. Even the insurance industry admitted this internally. In 1986, Maurice R. Greenberg of American International Group told an insurance audience in Boston that the industry's problems were due to price cuts taken "to the point of absurdity" in the early 1980s. Had it not been for these cuts, Greenberg said, "[T]here would not be 'all this hullabaloo' about the tort system."[3]

Business Week magazine also explained in a January 1987 editorial:

> Even while the industry was blaming its troubles on the tort system, many experts pointed out that its problems were largely self-made. In previous years the industry had slashed prices competitively to the point that it incurred enormous losses. That, rather than excessive jury awards, explained most of the industry's financial difficulties.[4]

Again today, the country is experiencing another so-called insurance "crisis," or "hard market," this time impacting property as well as medical malpractice lines with rates going up 100 percent or more for some.

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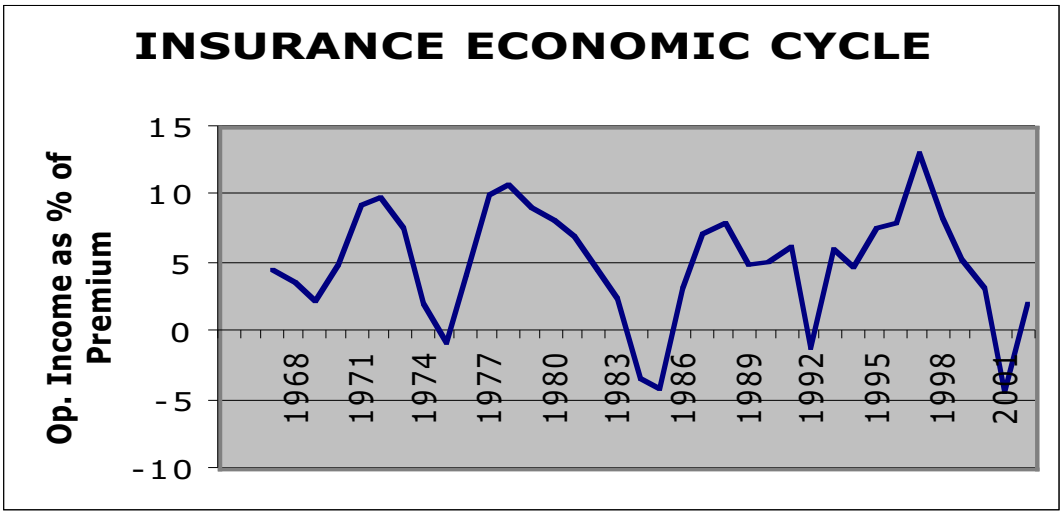
[1] Francis X. Bellotti, Attorney General of Massachusetts, et al., *Analysis of the Causes of the Current Crisis of Unavailability and Unaffordability of Liability Insurance* (Boston, MA: Ad Hoc Insurance Committee of the National Association of Attorneys General, May 1986).

[2] *See, e.g.*, New Mexico State Legislature, Report of the Interim Legislative Workmen's Compensation Comm. on Liability Insurance and Tort Reform, Nov. 12, 1986; Michigan House of Representatives, Study of the Profitability of Commercial Liability Insurance, Nov. 10, 1986; Insurance Comm. Pennsylvania House of Representatives, Liability Insurance Crisis in Pennsylvania, Sept. 29, 1986.

[3] Greenwald, "Insurers Must Share Blame: AIG Head," *Business Insurance*, March 31, 1986.

[4] "What Insurance Crisis?" *Business Week*, January 12, 1987.

The following chart shows the national cycle at work, with premiums stabilizing for 15 years following the mid-1980s crisis. (The 1992 data point was not a classic cycle bottom, but reflected the impact of Hurricane Andrew and other catastrophes in that year.)



Prior to late 2000, the industry had been in a soft market (characterized by low rates) since the mid-1980s. The strong financial markets of the 1990s had expanded the usual six- to ten-year economic cycle. No matter how much they cut their rates, the insurers wound up with a great profit year when investing the float on the premium in this amazing stock and bond market. (The "float" occurs during the time between when premiums are paid into the insurer and losses paid out by the insurer —*e.g.*, there is about a 15-month lag in auto insurance and a 5 to 10 year lag in medical malpractice.) Further, interest rates were relatively high in recent years as the Fed focused on inflation.

But in 2000, the market started to turn with a vengeance and the Fed cut interest rates again and again. This took place well before September 11th. The terrorist attacks sped up the price increases, collapsing two years of anticipated increases into a few months and leading to what some seasoned industry analysts see as gouging.[5] However, the increases we are witnessing are mostly due to the cycle turn, not the terrorist attack or any other cause. This is a classic economic cycle bottom.

In hard market periods, as we are currently experiencing, insurers will increase reserves as a way to justify price increases. In fact, the current insurance "crisis" rests significantly on a jump in loss reserves in 2001. Historically, reserves have been later "released" to profits during the "softer" market years. For example, according to a June 24, 2002, *Wall Street Journal* front page investigative article, St. Paul, which until 2001 had 20 percent of the national med mal market, pulled out of the market after mismanaging its reserves. The company set aside too much money in reserves to cover malpractice claims in the 1980s, so it "released" $1.1 billion in reserves,

[5] "[T]here is clearly an opportunity now for companies to price gouge — and it's happening. . . . But I think companies are overreacting, because they see a window in which they can do it." Jeanne Hollister, consulting actuary, Tillinghast-Towers Perrin, quoted in "Avoid Price Gouging, Consultant Warns," *National Underwriter*, Jan. 14, 2002.

which flowed through its income statements and appeared as profits. Seeing these profits, many new, smaller carriers came into the market. Everyone started slashing prices to attract customers. From 1995 to 2000, rates fell so low that they became inadequate to cover malpractice claims. Many companies collapsed as a result. St. Paul eventually pulled out, creating huge supply and demand problems for doctors in many states.[6]

However, lawmakers and regulators (and the general public) are now being told by insurance and medical lobbyists that doctors' insurance rates are rising, and companies are pulling out of the market, due to increasing claims by patients, rising jury verdicts, and exploding tort system costs in general. The insurance industry argues and, worse, convinces doctors and some lawmakers to believe that patients who file medical malpractice lawsuits are being awarded more and more money, leading to unbearably high losses for insurers. Medical malpractice insurers state that to recoup money paid to patients, insurers are being forced to raise insurance rates or, in some cases, pull out of the market altogether.

In fact, none of this is true. Americans for Insurance Reform has released a new study, *Stable Losses/Unstable Rates,* showing that since 1975, medical malpractice paid claims per doctor in this country have tracked medical inflation very closely (slightly higher than inflation from 1975 to 1985 and flat since). In other words, payouts have risen almost precisely in sync with medical inflation. Moreover, contrary to what the insurance and medical lobbies have alleged, the years 2001 and 2002 saw no "explosion" in medical malpractice insurer payouts or costs to justify sudden rate hikes. In fact, rather than exploding, inflation-adjusted payouts per doctor dropped from 2001 to 2002. These data confirm that neither jury verdicts nor any other factor affecting total claims paid by insurance companies that write medical malpractice insurance have had much impact on the system's overall costs over time.

Second, while payouts closely track medical inflation, medical malpractice premiums are quite another thing. They do not track costs or payouts in any direct way. Since 1975, the data show that in constant dollars, per doctor written premiums — the amount of premiums that doctors have paid to insurers — have gyrated almost precisely with the insurers' economic cycle. Moreover, medical malpractice insurance premiums rose much faster in 2002 than was justified by insurance payouts. This hike is similar to the rate hikes of the past, which occurred in the mid-1980s and mid-1970s and were not connected to actual payouts.

Where's the Crisis?

On August 29, 2003 – the Friday before Labor Day weekend – the General Accounting Office report *Medical Malpractice: Implications of Rising Premiums on Access to Health Care* was released to the public. The report had been requested by congressional Republicans. The GAO report examined claims by the American Medical Association (AMA) and state medical societies that a widespread health care access "crisis" exists as a result of doctors' medical malpractice insurance problems. The AMA has labeled 19 states as so-called "crisis" states. Massachusetts is considered by the AMA to be a "problem" state. It is this designation that has apparently led

[6] Christopher Oster and Rachel Zimmerman, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, June 24, 2002.

to the current proposal. *Yet, Massachusetts has more physicians per capita than any other state in the country,*[7] *and ranks seventh of the fifty states in the number of OB/GYNs per capita.*[8]

Similarly, the one so-called "crisis" state in New England, Connecticut, ranks second in the nation in the number of OB/GYNs per capita and fourth in physicians per capita, and the other alleged "crisis" state in the Northeast, New York, ranks third in the nation in the number of OB/GYNs and second in physicians per capita.[9] These and other findings with regard to states that have been designated as in "crisis" by the AMA should raise significant questions as to whether OB/GYNs in Massachusetts are, in fact, experiencing any sort of "crisis" as a result of the state's legal system.

GAO found claims about a current or impending crisis to be false or widely exaggerated. To the extent there are a few access problems, many other explanations can be established. In fact, the health care access problems that GAO could confirm were isolated and the result of numerous factors having nothing at all to do with the legal system. Specifically, GAO found that these pockets of problems "were limited to scattered, often rural, locations and in most cases providers identified long-standing factors in addition to malpractice pressures that affected the availability of services."

With regard to obstetrics practices in two high profile so-called "crisis' states – Nevada and West Virginia – GAO found:

> In Nevada, 34 OB/GYNs reported leaving, closing practices, or retiring due to malpractice concerns; however, confirmatory surveys conducted by the Nevada State Board of Medical Examiners found nearly one-third of these reports were inaccurate—8 were still practicing and 3 stopped practicing due to reasons other than malpractice. Random calls [GAO] made to 30 OB/GYN practices in Clark County found that 28 were accepting new patients with wait-times for an appointment of 3 weeks or less.
> . . . .
>
> In West Virginia, although access problems reportedly developed because two hospital obstetrics units closed due to malpractice pressures, officials at both of these hospitals told [GAO] that a variety of factors, including low service volume and physician departures unrelated to malpractice, contributed to the decisions to close these units. One of the hospitals has recently reopened its obstetrics unit.

As far as what the insurance industry is actually experiencing, newly-released data shows that insurance company profits, including those of medical malpractice insurers, are booming and insurance analysts are privately raving about it. According to the September 15, 2003, *Business Insurance* article entitled "Market Conditions Still Ripe for Insurer Profitability; Buyers to See

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[7] *See U.S. Census Bureau, Statistical Abstract of the United States: 2002*, Table 147, http://www.census.gov/prod/2003pubs/02statab/health.pdf.
[8] *New York State Conference of Blue Cross and Blue Shield Plans, The Facts About . . . New York's Physician Supply, at* http://files.veranet.net/1163/physician_supply0603.pdf (last visited Nov. 18, 2003).
[9] *New York State Conference of Blue Cross and Blue Shield Plans, The Facts About . . . New York's Physician Supply, at* http://files.veranet.net/1163/physician_supply0603.pdf (last visited Nov. 18, 2003).

Rate Hikes Ease," 14 property/casualty insurers saw a 35.9 percent increase in net income, to $7.5 billion, in the first half of 2003. Only Hartford booked an $888 million first-half loss, reflecting a $3.91 billion pretax charge for asbestos reserves in the first quarter.

By far the largest insurer reporting was American International Group, a major medical malpractice writer. AIG's net income increased by 30.3% in the first half of 2003, and it had a shockingly low combined ratio of 92.7%. That means it is making a lot of money even before adding in investment income.

Here's what some insurance analysts had to say about the first half 2003 results, according to *Business Insurance:*

> "I think the industry did fantastic, and my expectation is that we'll see more of the same in the second half." — Chris Winans, senior property/casualty analyst, Lehman Bros.
>
> There have been some "amazing cash flow numbers." — Stephan Petersen, Cochran, Caronia & Co.
>
> "Underwriting margins should remain good and, in fact, likely improve modestly because *price increases have been exceeding claims inflation* for the most part." (emphasis added) — Jay Cohen, Merrill Lynch.
>
> "I think it's going to continue to get better. I don't see any clouds on the horizon." — James Inglis, Philo Smith & Co.

In addition to undermining insurers' arguments that they are suffering gigantic loses due to claims and payouts – an assertion that underlies their principal argument for this proposal and other "tort reform" – this new data has additional significance: It may be signaling the end of the hard market. Americans for Insurance Reform spokesperson J. Robert Hunter, Director of Insurance for the Consumer Federation of America, said, "As in previous insurance cycles, the insurers are raking in the dollars, belittling their results as 'inadequate,' hiding much of their spoils in massive reserve hikes and, quietly, starting to compete again, setting the stage for the soft market, and lower prices, ahead."

Insurance Industry Reform is the Only Answer to Prevent Future Insurance "Crises"

So what can we do? First, wait for the hard market to end before even considering taking away patients' rights. Rates will stabilize soon. As Hunter put it in an April 2003 report by the Consumer Federation of America, "This classic turn after two years of skyrocketing premiums is good news for the hard-pressed buyers of commercial insurance. While there may be some increases yet ahead for some specific commercial buyers, the end of the hard market is clearly at hand for most business consumers."

Second, the causes and solutions to these insurance problems lie with the insurance industry, not the legal system. Unless fundamental changes in insurance industry practices are made, the cyclical price-gouging of policy holders will never end.

In July 2002, AIR sent letters to all 50 state insurance commissioners, including Massachusetts, outlining a number of steps that each state should immediately pursue. AIR wrote:

> In view of the excessive rate increases, price-gouging and tight underwriting that have hit certain lines of insurance this year, including the homeowners and medical malpractice lines, and recent reports about the questionable business and accounting practices of some insurers that are intensifying the impact of the economic cycle of the insurance industry,[10] Americans for Insurance Reform believes it is imperative that insurance regulators take immediate steps to impose a new regime of corporate responsibility and accountability on this industry whose business practices are wreaking havoc on the American economy. This letter details our recommendations for investigations, audits, and reforms.

The following were AIR's recommendations:

> 1. Investigations and Audits
>
> There must be a full and thorough investigation of the insurance companies' data to determine if there are errors and over-reserving in the data. In particular, we are asking that you order an investigation to determine:
>
> > The extent to which the extraordinarily high profitability of the insurance industry during much of the 1990s . . . is related to the performance of interest rates and the stock market during those periods;
> >
> > The extent to which today's rate increases are an attempt to recoup money that insurers lost in the stock market or in other poorly-performing assets;
> >
> > The extent to which insurers are adversely affected by today's low interest rates;
> >
> > Whether insurers' estimates of their future claims payments, which are the basis for rate increases, are unreasonably high today; and
> >
> > Whether it is proper, or lawful, for insurers to seek substantial rate increases despite having hugely increased their surplus–the money they have "in the bank," with policyholder-supplied funds, particularly if the insurer is overcapitalized.
>
> In addition, we urge you to institute, or seek statutory authority to institute, annual, rather than the typical once-every-three-years, audits of insurance companies operating in your

[10] For example, on June 24, 2002, the *Wall Street Journal* ran a front-page investigative story that reported, among other things: "Following a cycle that recurs in many parts of the business, a price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims. . . . Some of these carriers had rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly $3 billion last year." Moreover, "[i]n at least one case, aggressive pricing allegedly crossed the line into fraud."

state. These annual audits, we believe, should ascertain whether the companies are engaging in questionable accounting practices and whether their business and investment practices, by failing to take into account cyclical economic downturns, present unacceptable financial risks for insurance consumers and shareholders.

2. Specific Reforms. The state insurance commissioner should:

Regulate excessive pricing. One cause of the cycle is the lack of regulatory action to end excessive and inadequate rates during the different phases of the cycle. Please start now by regulating the excessive prices being charged by insurers today in your state. At least hold the necessary hearings to determine if the prices are not excessive.

Advise your legislators that the solution to prevent shock rate increases such as we are now experiencing is insurance reform, not "tort reform."

Freeze particularly stressed rates until the examination of the prices and remarkable jumps in loss reserves can be fully analyzed. For instance, medical malpractice and homeowner rates should be frozen. A roll back of unjustified rate increases that have already taken effect should then be in order. (The manner in which insurance rate rollbacks can be written and implemented to comply with all Constitutional requirements is explained in *Calfarm Ins. Co. v. Deukmejian*, 48 Cal. 3d 805 (1989), and *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). These cases substantially upheld Prop 103, the California insurance reform initiative that rolled back auto insurance rates by 20%.)

Require that risks with poorer experience pay more than good risks in lines of insurance where such methods are not in use today. For example, require medical malpractice insurers to use claims history as a rating factor, and to give that factor significant weight. Auto insurers use an individual's driving record as a rating factor; workers' compensation insurers use the employer's loss experience as a rating factor– so-called "experience mod." Malpractice insurers should do the same. In addition, you should require all medical malpractice insurers to offer all "good" doctors– i.e., all doctors meeting an objective definition of eligibility based on their claims history, their amount of experience and perhaps other factors – the lowest rate.

Reduce the percentage of assets that insurers can invest in stocks or other risky assets. Insurers should not be permitted to raise their rates in order to recoup losses on stocks or other risky assets. The less risky their investments, the more secure policyholders are, and the more stable are rates.

Create a standby public insurer to write risks when the periodic cycle bottoms and hard markets occur, such as a medical malpractice insurer funded by a start-up loan from the state to compete with the existing malpractice carriers. Several states have created such carriers to write workers' compensation, and in many states such carriers have helped bring down workers'

comp rates. Similarly structured medical malpractice insurers should have similar success.

More strongly regulate auto and homeowners insurance to prevent shock price increases and insecurity for policyholders. For example, you must prevent insurers, like State Farm, from overreacting by not writing new business in some states and by adopting draconian underwriting rules for renewal business. If the rate increases are shown to be high due to corporate policy (such as State Farm holding down prices as a marketing strategy), prices should not be allowed to go up suddenly but be spread over at least a three-year period to avoid "sticker shock" for your state's citizens.

Ask NAIC to stop implementation of the deregulation of commercial rates and forms which NAIC is unwisely pushing at this time. Oppose the implementation of such deregulation in your state.

Clearly, insurance rate regulation has helped to slow rate increases in some states, particularly in the medical malpractice lines. Nowhere has this been more evident than in California, a state that in 1988 passed the strongest insurance reform law in the country.

In September 2003, the California Insurance Commissioner ordered the state's second largest medical malpractice insurer, SCPIE Indemnity, to slash its proposed rate increase for doctors by 36 percent after an eight-month regulatory investigation of the firm's rate request. The investigation was conducted pursuant to California's 1988 insurance reform law, Proposition 103, which created a "prior approval" regulatory system that requires insurers to justify rate hikes and allows the public to challenge excessive rate requests. The ruling was in response to the first-ever consumer group challenge to a medical malpractice insurance rate hike request, brought by the Foundation for Taxpayer and Consumer Rights (FTCR), a California nonprofit organization.

SCIPIE requested a 15.6 percent hike but the Commissioner allowed only a 9.9 percent increase. According to the FTCR, "the net impact is a $16 million savings for the insurer's 9,000 physicians in 2003 and an additional $7.2 million of savings in next year's premiums."

In other states with strong insurance regulatory laws, malpractice insurers are now withdrawing requests for dramatic increases, or seeing those requests denied. For example, under a new Kentucky directive that requires insurers to seek prior approval if they hope to raise premiums more than 25 percent, ProNational Insurance Co. withdrew its request for a 57 percent increase after a hearing by the state Insurance Commissioner and her subsequent request that ProNational reconsider its request. In New York, insurers asked for a 19 percent increase in malpractice premiums, but the state Insurance Department approved an increase of less than half that size, averaging 8.5 percent. A spokesperson for the department explained: "Basically, we didn't see any justification for that big of an increase."

On the other hand, trying to remedy insurance problems by addressing the legal system has never worked. The Center for Justice & Democracy's 1999 study, *Premium Deceit —the Failure of "Tort Reform" to Cut Insurance Prices*, found that tort law limits enacted since the mid-1980s

have not lowered insurance rates in the ensuing years. Some states that resisted enacting any "tort reform" experienced low increases in insurance rates or loss costs relative to the national trends, and some states that enacted major "tort reform" packages saw very high rate or loss cost increases relative to the national trends. In other words, there was no correlation between "tort reform" and insurance rates.

More recently, Weiss Ratings, an independent insurance-rating agency, found that between 1991 and 2002, states with caps on non-economic damage awards saw median doctors' malpractice insurance premiums rise 48 percent -- *a greater increase than in states without caps*. In states without caps, median premiums increased only 36 percent. Moreover, according to Weiss, "median 2002 premiums were about the same" whether or not a state capped damage awards.

But don't just take our word for it. The following quotes from the American Tort Reform Association and the American Insurance Association (AIA) confirm this as well:

- "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." Sherman Joyce, president of the American Tort Reform Association, *Liability Week* (July 19, 1999).
- "[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years.'" Victor Schwartz, *Liability Week* (July 19, 1999).
- "Insurers never promised that tort reform would achieve specific savings." Debra Ballen, AIA executive vice president, March 13, 2002 news release.

In sum, volcanic eruptions in insurance premiums for doctors have occurred three times in the last 30 years – in the mid-1970s, again in the mid-1980s, and now today. The cause is always the same: a drop in investment income for insurers compounded by underpricing in prior years. Each time, insurers have tried to cover up their mismanaged underwriting by blaming lawyers and the legal system. This is completely without basis.

Eventually, as in the late 1980s, the insurance cycle will flatten out on its own, rates will stabilize and availability will improve. The flattening of rates will have nothing to do with tort law restrictions enacted in particular states, but rather to modulations in the insurance cycle everywhere. Trying to solve a widespread insurance problem by addressing the legal system and taking away patients' rights has failed in the past. It will fail again. Only effective insurance reforms will stop this and future cyclical insurance crises.

THE FALLACY OF THE WORKERS' COMPENSATION MODEL

For 30 years, the insurance industry and other special interests have been trying to force the sick and injured to waive their Seventh Amendment right to trial by jury and have their disputes resolved outside the court system. In some ways, this proposal is no different. But basing it on the disastrous workers' compensation model is a truly terrible idea.

Workers' compensation is rife with problems. Employers who pay into it, employees who rely on it, analysts who look at it, and scholars who study it all have a long list of complaints about how it doesn't work. It is a heavily bureaucratic adversarial system that shortchanges injured

workers, even while employers are struggling throughout the nation with rapidly rising workers' compensation insurance rates. And to the extent that rate reductions have taken place, they inevitably have come at the expense of the injured, where lawmakers have slashed benefits and pushed many of the injured entirely out of the system.

Workers' Compensation – Bad for the Injured; Payday for Insurers

The theory behind programs like workers' comp is that in return for giving up the right to use the civil justice system, those who are injured should be able to avoid lengthy delays in receiving care or compensation and should have this right without having to litigate in an adversarial proceeding. The truth, however, is that workers' comp has utterly failed to deliver on any of those promises.

The basic reason is that once codified, any kind of statutory administrative system is at the whim of industry money and the regular influence-peddling that reaches legislators. Indeed, over the years, lawmakers in virtually every state have steadily chipped away at workers' comp benefit levels and definitions of workplace injuries. As a result, increasing numbers of workers, particularly those with permanently disabling injuries, are finding themselves barely able to survive. Some of this "chipping away" took place in Massachusetts in 1991, when disability benefits were significantly reduced. There is no reason to believe that patients' benefits would not be subjected to similar reductions.

The problems with workers' comp have been around for years, making it even more astounding that lawmakers should consider workers' comp any sort of model program. According to the 1972 Report of the National Commission on State Workmen's Compensation Laws, headed by John F. Burton, Jr., "When Congress enacted the Occupational Safety and Health Act of 1970, they declared that 'in recent years serious questions have been raised concerning the fairness and adequacy of present workmen's compensation laws.'" Two years later, the commission found that "State workmen's compensation laws are in general neither adequate or equitable."

It seems things have only gotten worse in the subsequent 31 years. As in the past, workers' compensation today does a terrible job compensating many of those injured on the job. Benefits, even if they were initially adequate, fall over time as insurers, employers or, in this case, hospitals and health care providers, will inevitably pressure legislators to reduce compensation. *Consumer Reports*, which was highly critical of workers' comp in a 2000 report, described this pattern:

> In the early 1990s, state legislatures across the nation, at the behest of insurance carriers and the business community, passed reform laws designed to improve the system. They did--for insurers and businesses. Workers-comp insurance, once the money-loser of the industry, grew fat with profits. And businesses saw premiums drop substantially from 1992 to 1996, a development that public officials say stimulates job growth.
>
> The old system needed changing, many agree. But instead of targeting insurance bureaucracies and employer fraud--two key problems that still exist--the new laws have generated profits for insurers and savings for employers mainly at the expense of injured workers. Those laws clamped down on benefits, raised eligibility requirements, and put

> medical treatment mainly in the hands of insurance companies, which can delay or deny medical care or income payments.[11]

A 2001 study by the Rand Corporation's Institute for Civil Justice estimated that partially disabled workers injured in one state — California — generally have received less than 60 percent of their pre-injury income over a five-year period and less than 50 percent of pre-injury earnings over a ten-year period.[12] And in a June 2002 report, the nonprofit National Academy of Social Insurance found that for every $100 in wages, workers' comp benefits had declined by 39% to $1.03 in 2000, the eighth consecutive year that benefits had dropped as a percentage of wages.[13]

What's more, because of the inadequacy of benefits, it is when injuries are most severe, as in the case of serious brain damage or other catastrophic injury, that the system fails most completely. Virginia has had a somewhat similar program in place for the last 15 years, covering babies who are brain-damaged at birth. This proposal is described in more detail at the end of this statement. According to a series of investigative reports in the *Richmond Dispatch*, the program prevents many catastrophically-injured children from receiving adequate benefits: "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 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."[14]

In medical malpractice cases, the problems would be especially acute if non-economic damages were limited, as they are under workers' comp. Non-economic damages compensate injured consumers for intangible but real injuries, like infertility, permanent disability, disfigurement, pain and suffering, loss of a limb, or other physical impairment. Abolishing or limiting non-economic damages will have a disproportionate effect on patients who do not have high wages – like women who work inside the home, children, or the poor, who are thus more likely to receive a greater percentage of their compensation in the form of non-economic damages if they are injured.

Further, to "obtain sign off" from malpractice insurers, the proposal acknowledges that it must "guarantee" no higher premiums and, to do so, must create a schedule of damages that "seem reasonable" to insurers and convince insurers that there will not be a "dramatically larger number of injuries eligible for compensation." Given the well-known Harvard study that found that 78% of victims of preventable errors in hospitals do not make malpractice claims,[15] and the fact that

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[11] "Workers Comp: Falling Down on the Job," *Consumer Reports*, Feb. 2000.
[12] *Trends in Earnings Loss from Disabling Workplace Injuries in California*," Rand Institute for Civil Justice, 2002.
[13] *Workers' Compensation: Benefits, Coverage and Costs*, National Academy of Social Insurance, June 2002.
[14] Bill McKelway, "Danville Has High Birth-Injury Rate; Critics Say Virginia Law Shields Doctors from Lawsuits," *News Virginian*, June 1, 2003.
[15] Harvard Medical Study Group, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York*, 1990.

this system should theoretically compensate all such patients, a schedule of damages that seems "reasonable" to insurers who must guarantee no premium increase will have to be terrifyingly measly, particularly for the most severely injured.

After the changes to the workers' comp laws in the 1990s, "workers-comp carriers had become the envy of the insurance industry, with annual operating profits of 20 percent."[16] How did they do that? According to *Consumer Reports*:

> The new laws not only reduced benefits but also made them harder to collect. In many states, the burden is now on the workers to prove by a preponderance of the evidence that their injuries occurred as a result of their job and not poor health habits, aging, or a pre-existing medical condition, To win a claim, says [a] workers-comp attorney . . ., a worker practically has to be "convicted of injury on the job." The result is that ill and injured workers now must fight a series of battles: first, to get medical care; next, to withstand exams by insurance-company doctors who have an incentive to find excuses not to pay; then, to get a fair assessment of any permanent disability; and finally, to win a hearing if there's a dispute.[17]

Meanwhile, workers' compensation programs have saved employers and their insurance carriers billions of dollars. According to John Burton, Dean of the School of Management and Labor Relations at Rutgers University and Chairman of the National Commission on State Workers' Compensation Laws, in much of the 1990s insurer profits increased dramatically and employers' workers' comp costs dropped, while benefit payments to workers decreased substantially. Burton found that in 1995 alone, insurers took in over $124 for every $100 of net expenses. Similarly, the AFL-CIO discovered that in 1998 the average profit on workers' compensation insurance was 7 percent, as compared with 3.7 percent and – 0.7 percent for auto insurance and homeowners' insurance, respectively.[18] As for employer savings, the National Academy of Social Insurance reports that employer workers' comp costs had fallen by 42 percent relative to wages between 1993 and 2000.[19]

Litigation Will Not Be Reduced – But Patients Will Be Greatly Disadvantaged.

This proposal not only will not reduce litigation, it will do little to reduce patients' burdens while forcing them to litigate in forums that are unfair to patients.

The workers' comp system is instructive. This was a system that was basically conceived as "no-fault." Yet the adjudicatory burdens on the injured are substantial. As far back as 1972, the National Commission on State Workers' Compensation Law stated, "The no-fault concept and prescribed benefits, it was assumed, would reduce the need for litigation. The complexities of the law and doubts about the sources and nature of impairments have dashed these expectations. . . . Substantial litigation results from efforts to determine which injuries or

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[16] "Workers Comp: Falling Down on the Job," *Consumer Reports*, Feb. 2000.
[17] *Ibid.*
[18] AFL-CIO Workers Compensation Comparison Tables, 2001.
[19] *Workers' Compensation: Benefits, Coverage and Costs*, National Academy of Social Insurance, June 2002.

diseases are work-related and compensable. There are both legal and medical questions in each claim." The Commission also found that passive agency administration resulted in excessive litigation, delay and expense.

When the American Bar Foundation looked at no-fault proposals in medical malpractice cases in the mid-1980s, during the last insurance "crisis," they noted, "While claiming that the main advantage of a no-fault mechanism is a streamlined recovery which presumably takes less time, less money and less hassle to receive the payback, no-fault proponents face the great problem of actually defining what is a compensable event." In these cases, a broad definitional category could be unworkable, since it is often impossible to tell whether a patient's injury was physician or hospital induced or a natural condition.[20]

The Massachusetts proposal is extremely vague in terms of what exactly an injured patient must prove to obtain compensation. However, using the legislative language of HB 1704, on which there were hearings last week, there could actually be *additional* burdens of proof placed on the injured beyond what is typically required in a medical malpractice case. In terms of causation, proving an "act or omission" that resulted in an injury, illness, or impairment is, essentially, no different than having to prove negligence. Any act or omission that causes such an injury would be, by definition, outside the normal standard of care.

Moreover, under the standards contained in HB 1704, there could also be an additional burden of proof on the injured patient that would not apply to them in a medical malpractice case: proving that the injury, illness, or impairment "is not within the range of medical outcomes ordinarily expected as foreseeable results of the patient's condition or of appropriately selected and administered treatment." This second burden seems particularly draconian when, say, a doctor fails to diagnose a condition, such as when the doctor misreads test results or fails to do appropriate tests. For example, if a doctor fails to diagnose a tumor that he or she should have, and that tumor then causes paralysis, the injured patient might still have a hard time with the second requirement, since it is foreseeable that a tumor in a certain area would result in paralysis (even though the doctor's negligence resulted in leaving the tumor untreated).

Where there are power and resource disparities between the parties, requiring patients to prove causation and other issues before an administrative tribunal, even one that did not consist of a biased panel controlled by health care and insurance professionals as proposed here, is very unfair to the patient. This is particularly true in the context of medical malpractice actions because the disputing parties are extremely ill-matched. The parents of catastrophically injured children who are in need of medical care, who are disabled or perhaps in pain, and who may have major medical expenses, are in a substantially weaker position than the medical establishment.

For example, a recent story about a child denied benefits under Virginia's birth-injury compensation program, which functions much as this proposed system would, described the lop-sided scene as follows: "Using material she tracked on the Internet and assessments from her daughter's pediatrician, Sue Ann Sochor found herself opposed at a hearing in March by a

[20] Taylor, "Alternatives to Tort Liability, An Overview," *Legal Liability and Quality Assurance in Newborn Screening*, American Bar Foundation, 1985.

lawyer from the Richmond based Hirschler Fleischer firm, a neurologist hired by the program and other experts paid by the program."[21]

Even neutral administrative tribunals do not offer the normal protections provided by the court system to neutralize imbalances between parties, *e.g.*, procedural and substantive rights like the right to know and rebut evidence through discovery, cross-examination and argument, civil rules of procedure, and an impartial judge who is guided by the substantive law. Rules of evidence and procedure are relaxed or not applied at all. When the *New England Journal of Medicine* compared alternative compensation systems with jury trials in medical malpractice cases in the late 1970s, they found that that the protection against bias and influence that a jury provides and the accuracy attained by complete and careful presentations in court would not be offset by any gains in efficiency an alternative system might provide.[22]

Some jury critics have said that jurors are unable to handle the evidence and law in medical malpractice and other complex cases, and that so-called "expert" tribunals, as envisioned here, are preferable. However, judges, who every day observe how juries function, have roundly rejected this suggestion. In March 2000, the *Dallas Morning News* and Southern Methodist School of Law sent questionnaires to every federal trial judge in the United States, its territories and protectorates – over 900 judges. About 65 percent (594) of the federal judges responded.[23]

The paper reported, "The judges' responses reflect a high level of day-to-day confidence in the jury system. . . . Only 1 percent of the judges who responded gave the jury system low marks. . . . Ninety-one percent believe the system is in good condition needing, at best, only minor work. . . . **Overwhelmingly . . . judges said they have great faith in juries to solve complicated issues**. . . . Ninety-six percent said they agree with jury verdicts most or all of the time. **And nine of 10 judges responding said jurors show considerable understanding of legal and evidentiary issues involved in the cases they hear**."[24]

Another problem will be the inability of patients to find attorneys to help them. Using workers' comp as a guide, attorneys who represent injured workers receive far less compensation than lawyers practicing in the tort system, reducing the number of attorneys willing to practice in this field and increasing the work of those who do. One can expect defendants to take advantage of this to the detriment of the injured, low-balling settlement offers that would grossly undercompensate patients.

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[21] Bill McKelway, "Old Rules Deny New Benefits; Children Rejected for Brain-Injury Program," *Richmond Times Dispatch*, June 5, 2003.
[22] Schwartz (M.D.), Komesar (J.D.), "Doctors, Damages and Deterrence," *New England Journal of Medicine*, (June 8, 1978).
[23] Allen Pusey, "Judges Rule in Favor of Juries: Surveys by Morning News, SMU Law School Find Overwhelming Support for Citizens' Role in Court System," *Dallas Morning News*, May 7, 2000.
[24] *Ibid.* (emphasis added).

In sum, as former Judge Harry Edwards of the U.S. Court of Appeals for the D.C. Circuit once noted, "inexpensive, expeditious and informal adjudication is not always synonymous with fair and just adjudication."[25]

Medical Errors Will *Increase* Under this Proposal as the Deterrence and Disclosure Functions of the Civil Justice System Are Disrupted

In the sensationalized debate over medical malpractice lawsuits, there is typically little discussion of perhaps their most critical function — making patients safer. Time and again, history has shown that lawsuits against health care providers create an economic incentive for them to practice safer. By the same token, when disputes are resolved without trial and without a public record, wrongdoers can prolong misconduct and suppress for years information about dangerous practices.

For example, under Virginia's Birth-Related Neurological Injury Compensation Program (discussed in greater detail below), which operates much as this proposed program apparently would, "[b]ecause the cases do not come to trial, there is no examination of the doctor and what occurred at birth, nor is there testimony from nurses or neurologists about a doctor's action."[26] National birth-injury experts have reportedly expressed fear about Virginia becoming a safe harbor for bad doctors due to this law.

Our judicial system recognizes that there are duties inherent in certain types of relationships, such as between a health care provider and a patient, and that anyone who breaches its duties ought to be subject to liability. When a controversy is resolved informally by an administrative tribunal, it has no legally binding effect on other controversies. There can be no expectation that others will follow the announced principle. Removing claims from the tort system like this circumvents rules about standards of conduct which have evolved over the years to protect patients who have no way to protect themselves. It disrupts the important functions of the tort system: deterrence of unsafe practices and the disclosure of dangers to the public, and the evolution of written precedents, which develop individual rights and responsibilities by others.

Workers' comp, on which this proposal is based, is a good example of how safety can be compromised when tort suits are eliminated. Professor Richard Abel has written that because the workers' compensation system is consciously designed not to reflect the full costs of accidents, it is an ineffective deterrent against workplace dangers. [27] The 1972 National Commission on State Workmen's Compensation Laws also found problems with workers' compensation systems' impact on deterrence.

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[25] Harry Edwards, "Hopes and Fears for Alternative Dispute Resolution," 21 Willamette L. Rev. 425 (1985).

[26] 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.

[27] Abel, "The Real Tort Crisis – Too Few Claims," 48 Ohio L.J. 443, 456 (1987) *See also* "Exceptions to the Exclusive Remedy Requirements of Workers' Compensation Statutes," Harvard L. Rev. 1647 (1983).

According to the Rand, researchers in 1982 expressed misgivings about the adequacy of the financial incentive which such systems provide for safety.[28] In particular, worker compensation incentives are inadequate for both insureds and self-insureds because the employer incurs less than the full economic and non-economic costs of an injury.

Moreover, workers rather than wrongdoers still bear a large portion of wage losses resulting from their injuries (in addition to pain and suffering), when the losses exceed the statutory limit. Under the negligence system, the wrongdoer would bear this cost. Thus, to the extent that insurance reduces the deterrent impact of financial liability, its effect is greater under workers' compensation than under negligence.[29]

In the mid-1980s, Ashford and Johnson found that employers bear less of the accident costs under workers' compensation than under negligence (9 percent vs. 13 percent). They suggest that while workers' compensation programs may allow more injured workers to receive some payments, this has been achieved primarily at the expense of non-negligent workers who otherwise could expect greater recovery under negligence rules. It has <u>not</u> been at the expense of employers, who pay less under workers' compensation than under negligence, and who likewise might be seen as enjoying a subsidy financed by non-negligent workers. It is, of course, also at the expense of workers who are injured since employers have failed to take safety precautions because of limited liability under the workers' compensation system.

Under workers comp., the trend has always been to blame workers for job injuries and do little to eliminate or reduce job hazards. According to the Massachusetts Coalition for Occupational Safety and Health (MassCOSH), "49 Massachusetts workers . . . died as a result of a workplace injury or illness in 2002. Most of these workers died from acute, traumatic injuries. For each worker who is killed on the job, there are 10 more who die from occupational disease — most whose names do not appear on this list and whose faces will never be known. In Massachusetts last year, an estimated 490 workers died from occupational disease, another 1,565 were diagnosed with cancer caused by workplace exposures, and 50,000 workers were seriously injured. . . . During the 17-year period, 1986-2002, 273 out of 351 cities and towns have had a worker killed on the job, most of these from acute traumatic injuries. This represents over two-thirds of all the municipalities in Massachusetts."[30]

Lawsuits are often the only means for the public and government regulators to learn about dangerous and unsafe practices. In other words, lawsuits protect us all, whether or not we ever go to court. Moreover, the amount of money saved as a direct result of this deterrence function — injuries prevented, health care costs not expended, wages not lost, etc. — is incalculable. Some have estimated this savings to be perhaps a trillion dollars a year.

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[28] Victor, "Workers' Compensation and Workplace Safety, The Nature of Employer Financial Incentives," Rand, The Institute for Civil Justice (1982).

[29] Ashford, Johnson, "Negligence vs. No-Fault Liability: An Analysis of the Workers' Compensation Example," 12 Seton Hall L. Rev. 747 (1982).

[30] *MassCOSH, Dying for Work in Massachusetts: The Loss of Life and Limb in Massachusetts Workplaces, at* http://www.masscosh.org/workersmemoriaexecsum.htm & http://www.masscosh.org/deathssummaries.htm (last visited Nov. 17, 2003).

Many academic scholars have written that the influence of jury verdicts in civil cases, of which there are relatively few, is vastly disproportionate to their number. Jury verdicts provide "signals" or warnings that certain types of practices will not be tolerated. According to the Rand Institute for Civil Justice, "The jury's decision in any particular case indicates the potential costs of engaging in behavior similar to the defendant's . . . Punitive damages are designed to punish a defendant for grossly inappropriate actions and, in so doing, to deter future such actions by signaling that their consequences can be severe."[31]

In medical malpractices cases, the *New England Journal of Medicine* reported in the late 1970s that replacing the tort system "might well abolish the deterrent signal or distort clinical decision making." [32] They found that fault systems that assess damages against the negligent doctor sends "signals" to other doctors that discourage future carelessness and reduce future damages. At best, such systems satisfy isolated individuals. They do not prevent or deter abuses.

Examples of cases around the country where patients or their families have been able to sue and have won improvements to existing safety standards by filing civil actions include the following:

Serious trauma patients not taken to trauma centers.

FACTS: on December 20, 1992, his best friend rushed 20-year-old Jason Griffith to an Ohio community hospital after being accidentally shot in the chest. Although Griffith was losing massive amounts of blood, his attending doctor — a fifth-year resident in general surgery — waited more than five hours before taking him to surgery. Griffith went into shock ten days later and ultimately suffered cardiopulmonary arrest and brain damage. He required constant care until his death in January 1994. His parents filed suit against the hospital and the doctors who treated him. The case settled for $2.5 million two days after the trial began.[33]

FACTS: On May 3, 1997, 37-year-old Joyce Lyons sustained abdominal injuries from a car accident on a rural road in Ohio. Lyons was admitted to Mary Rutan Hospital, subjected to a CT scan, and kept overnight. The following morning, Lyons' condition had worsened from internal bleeding, which required emergency surgery. Lyons was then flown by helicopter to a trauma center where she was operated on immediately. On May 12, after suffering complications, she underwent additional surgery; she died nine

[31] Erik Moller et al., *Punitive Damages in Financial Injury Jury Verdicts (*Rand Institute for Civil Justice, Doc. No. MR-888-ICJ, 1997); *see also* Marc Galanter, "Real World Torts: An Antidote To Anecdote," 55 Md. L. Rev. 1093 (1996); William M. Landes & Richard A. Posner, *The Economic Structure of Tort Law* (1987); Richard L. Abel, "The Real Tort Crisis – Too Few Claims," 48 Ohio St. L.J. 443 (Spring 1987).

[32] Schwartz (M.D.), Komesar (J.D.), "Doctors, Damages and Deterrence," *New England Journal of Medicine,* (June 8, 1978).

[33] Mark D. Somerson, "Lawsuits Might Move Trauma System Forward," *Columbus Dispatch*, June 1, 1997 (discussing *Griffith v. Booher*, No. 94CVA-09-6799 (Franklin County Ct. of Common Pleas, Ohio, settlement May 21, 1997)); *see also* Bruce Cadwallader, "Mount Carmel Lawsuit Settled; Insurers to Pay $2.5 Million in Pickerington Man's Death," *Columbus Dispatch*, May 27, 1997; Bruce Cadwallader, "Mount Carmel East Lawsuit Trial Begins," *Columbus Dispatch*, May 21, 1997; Mark D. Somerson, "Lawsuit Highlights Trauma Care Issue; Parents: Son Died for Lack of Timely Care," *Columbus Dispatch*, April 27, 1997.

days later. Lyons' husband filed a negligence suit against Mary Rutan and the doctors there who treated his wife. The jury awarded $5 million.[34]

EFFECT: On July 27, 2000, after nearly a decade of active opposition, Ohio enacted legislation that mandates that patients with serious trauma be transported to selected, certified trauma hospitals. The Griffith and Lyons cases "put a face to the numbers of 'preventable deaths' in Ohio, and I believe gave the Governor and sponsors of the legislation the leverage needed to enact this legislation."[35]

HMO forced psychiatrists to prescribe psychiatric drugs.

FACTS: On April 10, 2000, Dr. Thomas Jensen filed a lawsuit against Kaiser Permanente, California's largest health maintenance organization, after he was fired for refusing to prescribe medications for mental health patients whom he did not personally examine. Kaiser required psychiatrists to prescribe anti-depressant drugs for depression and anxiety at the recommendation of non-medical psychotherapists, such as social workers, family therapists, and social-work interns.[36]

EFFECT: The lawsuit prompted state regulators to investigate Kaiser's prescription policy. Faced with an onslaught of negative publicity arising from Jensen's lawsuit, Kaiser eliminated the practice in August 2000. Kaiser now requires psychiatrists to rely on their own examination of patients before writing prescriptions.[37]

Failure to properly monitor patient.

FACTS: Marilyn Hathaway suffered brain damage after an anesthesiologist failed to monitor her cardiopulmonary status during surgery. In 1983, Hathaway sued the physician for medical negligence. The jury awarded $5 million in damages.[38]

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[34] Kathryn L. Koehler, "Delay In Performing Surgery Cost Patient's Life; Late Operation Could Not Prevent Complications," *Ohio Lawyers Weekly*, Feb-. 28, 2000 (citing *Lyons v. Clarkston*, No. 978CVC-08-7796 (Franklin County Ct. of Common Pleas, Ohio, verdict Sept. 3, 1999)); *see also* Tim Doulin & Joe Hoover, "Family of Crash Victim Is Awarded $5 Million," *Columbus Dispatch*, Sept. 4, 1999; Mark D. Somerson, "Crash Victim's Care on Trial," *Columbus Dispatch*, Aug. 23, 1999.

[35] Letter from Gerald Leeseberg, dated Nov. 16, 2000 (Leeseberg is the attorney for the Griffith and Lyons families); *see also* Misti Crane, "Trauma Cases, Hospitals to be Matched," *Columbus Dispatch*, July 28, 2000; Mark D. Somerson, "Trauma System Would Save Hundreds of Lives," *Columbus Dispatch*, Sept. 7, 1997.

[36] Tony Fong, "Kaiser Sued Over Policy on Medicine; S.D. Psychiatrist Says Doctors Must Prescribe Drugs to Unseen Patients," *San Diego Union Tribune*, April 13, 2000; Sharon Bernstein & Davan Maharaj, "Kaiser Drug Policy Prompts State Inquiry," *Los Angeles Times*, April 12, 2000.

[37] "Kaiser Permanente has Reached a Settlement with Thomas Jensen, M.D. of San Diego," *Managed Care Week*, Vol. 10, No. 32, Sept. 11, 2000; Sharon Bernstein, "Kaiser Settles Doctor's Suit Over Drug Policy," *Los Angeles Times*, August 26, 2000; Tom Abate, "Kaiser to End Controversial Prescriptions," *San Francisco Chronicle*, May 3, 2000; Davan Maharaj, "Kaiser Tightens Rule On Writing Prescriptions," Los Angeles Times, May 3, 2000; "California Investigates Kaiser Prescriptions Policy," *BestWire*, April 17, 2000; Tom Abate, "State Probing Kaiser's Protocol for Depression; Prescriptions Allegedly Given without Exams," *San Francisco Chronicle*, April 13, 2000.

[38] *Frank v. Superior Court of the State of Arizona*, 150 Ariz. 228 (1986).

EFFECT: "After having to pay repeated medical malpractice claims arising from faulty anesthesia practices ... Arizona's malpractice insurance companies took action. For example, the Mutual Insurance Company of Arizona, which insures over 75 percent of the state's physicians, began levying a $25,000 surcharge on insurance premiums for anesthesiologists against whom claims had been made because constant monitoring of the patient was not performed during general anesthesia. As a result of litigation, adequate anesthesia monitoring during surgery has become a standard medical practice in Arizona."[39]

Staffing problem endangered patients.

FACTS: On January 26, 1998, Dr. Roberto C. Perez suffered severe brain damage after a nurse, who had been working over 70 hours a week and was just finishing an 18-hour shift, injected him with the wrong drug. Perez had been admitted to Mercy Hospital in Laredo, Texas, two weeks earlier after a fainting spell and was almost ready to be discharged. His family filed a medical malpractice suit, arguing that hospital administrators knew since 1994 that staffing problems existed yet failed to do anything about the nursing shortage. The case settled before trial, with the hospital paying $14 million.[40]

EFFECT: As part of the settlement, Mercy Hospital agreed that no nurse in the ICU would be allowed to work more than 60 hours per week.[41]

Bacterial infection spread to hospital roommate.

FACTS: In 1983, 72-year-old Julius Barowski contracted a bacterial infection from a fellow patient after undergoing knee replacement surgery. His condition required 11 hospitalizations and 9 surgeries; his leg lost all mobility. As the infection spread, he suffered excruciating pain and was institutionalized for depression until his death one year later. Barowski's representative filed suit, alleging that the hospital breached its own infection control standards. The jury awarded $500,000.[42]

EFFECT: "The Widmann ruling and similar cases have had a catalytic impact in health care facilities around the country. Facilities are much more attentive to the clinical importance of cleanliness in all its dimensions — hand-washing, routine monitoring of infection risks, and more vigorous reviews of hospital infection control protocols."[43]

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[39] Harvey Rosenfield, *Silent Violence, Silent Death* 57 (1994) at 56 (citing James F. Holzer, "The Advent of Clinical Standards for Professional Liability," *Quality Review Bulletin*, Vol. 16, No. 2 (Feb. 1990)).
[40] *Perez v. Mercy Hospital*, No. 98 CVQ 492-D3 (341st Judicial Dist., Webb County Ct., Tex., settlement Oct. 28, 1999); *Perez v. Mercy Hospital*, No. 98 CVQ 492-D3 (341st Judicial Dist., Webb County Ct., Tex., fourth amended original petition, filed Oct. 22, 1999) (on file with CJ&D).
[41] *Perez v. Mercy Hospital*, No. 98 CVQ 492-D3 (341st Webb County Ct., Tex., settlement Oct. 28, 1999); *Perez v. Mercy Hospital*, No. 98 CVQ 492-D3 (341st Judicial Dist., Webb County Ct., Tex., release and settlement agreement, Oct. 28, 1999) (on file with CJ&D).
[42] *Widmann v. Paoli Memorial Hospital*, No. 85-1034 (E.D. Pa., verdict Dec. 9, 1988); *see also* Harvey Rosenfield, *Silent Violence, Silent Death* 57 (1994), at 55-6.
[43] Harvey Rosenfield, *Silent Violence, Silent Death* 57 (1994) at 55-6.

Tube misinsertion caused death.

FACTS: Rebecca Perryman was admitted to Georgia's DeKalb Medical Center after suffering from kidney failure. While undergoing dialysis, a catheter inserted in her chest punctured a vein, causing her chest cavity to fill with blood. Perryman suffered massive brain damage and lapsed into a coma. She died two weeks later. Perryman's husband Henry filed suit against DeKalb and its Radiology Group, as well as the doctor who failed not only to spot the misplaced catheter in Perryman's chest x-ray but also to quickly respond to the victim's excessive bleeding. DeKalb and the Radiology Group settled before trial for an undisclosed amount; a jury awarded $585,000 against the doctor.[44]

EFFECT: "After the award, the radiology department instituted new protocol for verifying proper placement of catheters."[45]

Nurses feared consequences of challenging doctors' actions.

FACTS: On April 30, 1979, Jennifer Campbell suffered permanent brain damage after becoming entangled in her mother's umbilical cord before delivery. Although a nurse had expressed concern when she noticed abnormalities on the fetal monitor, the obstetrician failed to act. Despite the doctor's unresponsiveness, the nurse never notified her supervisor or anyone else in her administrative chain of command. The child developed cerebral palsy, requiring constant care and supervision. Evidence revealed that the hospital lacked an effective mechanism for the nursing staff to report negligent or dangerous treatment of a patient. In addition, the nursing supervisor testified that an employee could be fired for questioning a physician's judgment. The jury awarded the Campbells over $6.5 million.[46]

EFFECT: "Because of this verdict and its subsequent publicity, hospitals throughout North Carolina have adopted a new protocol that allows nurses to use their specialized training and judgment on behalf of patients, without risking their jobs."[47]

Verdicts and settlements in medical malpractice cases have forced improvements in health care and led to the elimination of many unsafe practices, saving millions of people from injury or death. When a controversy is resolved outside the court system, it has no legally binding effect on other controversies. There can be no expectation that others will follow the announced principle. Removing claims from the tort system, such as proposed here, will ultimately circumvent rules about standards of conduct that have evolved over the years to protect patients who have no way to protect themselves.

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[44] *Perryman v. Rosenbaum et al.*, No. 86-3453 (DeKalb County Super. Ct., Ga., verdict June 5, 1991).
[45] Thomas Koenig & Michael Rustad, *In Defense Of Tort Law* (2001) (citing letter from W. Fred Orr III, Henry Perryman's attorney, dated April 26, 1994).
[46] *Campbell v. Pitt County Memorial Hospital, Inc.*, 84 N.C. App. 314 (1987); *see also* Laura Mahlmeister, "The Perinatal Nurse's Role in Obstetric Emergencies: Legal Issues and Practice Issues in the Era of Health Care Redesign," *J. of Perinatal & Neonatal Nursing* (Dec. 1996); Harvey Rosenfield, *Silent Violence, Silent Death* 57 (1994).
[47] Harvey Rosenfield, *Silent Violence, Silent Death* (1994) at 57.

Secrecy about Errors and Injuries Will Continue Under the Proposed System

Massachusetts may provide the best proof in the country that litigation and liability risks are *not* the reasons for secrecy about medical errors. Massachusetts hospitals have some of the strongest protections from liability in the nation, since nearly all fall under the state's charitable immunity laws that cap their liability at $20,000.[48] Yet, even though they run little risk of liability for errors, "statistics suggest, and leading experts confirm, that doctors and hospitals around Boston — widely considered the medical capital of the world — are vastly underreporting their mistakes to regulators and the public."[49] According to a February 2003 *Boston Magazine* article:

> In 2001, Massachusetts hospitals reported 982 serious incidents, or medical errors, to state regulators, up from 636 five years earlier, but still an average of just three reports per day. In New York state, by comparison, hospitals submitted nearly 30,000 reports, or 82 per day. In fairness, that disparity is mostly due to the different ways the states define a medical error: New York studies every little complication; Massachusetts, only major incidents. Still even New York is criticized for disclosing fewer medical errors than actually occur, and with a population only three times that of Massachusetts, it is reporting more than 30 times as many. One doctor who was a member of a Massachusetts oversight committee says statistics show there should be 10 reports of medical errors per 100 hospital beds each year. In fact, hospitals in this state are disclosing roughly three. Even when they are reported, one Harvard School of Public Health professor says, many medical errors are barely investigated because of a lack of resources.[50]

It is misguided to think that fear of litigation is the only, or even principal, reason that doctors and hospitals do not report errors. According to *Boston Magazine*, "doctors, either out of shame, a fear of being sued or disciplined, or anxiety about their reputations, rarely talk openly about their errors. . . . 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."

This "white wall of silence" would not just stop the day Massachusetts adopted the proposed system. In fact, under the similar birth-injury program in place in Virginia, obstetricians are not even asked to explain what happened, and the family may never learn anything about what caused a catastrophic injury. Not a single case in the program's 15-year history has 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."[51] One mother of a daughter with cerebral palsy and other severe disabilities testified before the Virginia House that the program

[48] Mass. Gen. Laws ch. 231, § 85K (2003).
[49] Doug Most, "The Silent Treatment," *Boston Magazine*, Feb. 2003.
[50] *Ibid.*
[51] 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.

"has evolved from a model of care for severely disabled children to . . . safe haven for physicians and hospitals who, in some cases, are directly responsible for these catastrophic injuries."[52]

It should also be noted that the proposal outline states that the National Practitioner Databank, which seeks to record incidents of negligence in the practice of medicine, "pollutes" the medical industry's attitude and encourages secrecy. In every other context — corporate America, government, and any other industry — openness and letting the light shine on wrongdoing is seen as an important step in bringing about fairness and positive change. While this proposal outline expresses almost no concern about increasing patient safety, it is still astounding that the drafters would go so far as to refer to disclosure of wrongdoing as polluting.

Pre-Dispute Notice Provisions are Fundamentally Unfair to Patients

Under this proposal, pregnant women would have to sign an agreement to waive their rights to sue in the event their child is injured at birth, or be turned away. This is in direct violation of AMA policy, which has said in the context of pre-dispute binding managed care arbitration that such agreements are fundamentally unfair to patients.

The AMA view was most recently articulated in a 1998 report released jointly by the AMA, the American Bar Association and the American Arbitration Association, which studied such mandatory binding arbitration agreements, entitled *Health Care Due Process Protocol.*[53] As a result of this study, the American Arbitration Association affirmed in its Health Care Policy Statement that it will not participate in arbitration between a patient and health care provider if the patient was forced to give up their rights before malpractice occurred.[54]

In the report's recommendations, the organizations jointly found that any alternative resolution process (ADR), like arbitration, must abide by due process considerations and must be fundamentally fair. Specifically, they found:

> The agreement to use ADR should be knowing and voluntary. Consent to use an ADR process *should not be a requirement for receiving emergency care or treatment.* In disputes involving patients, binding forms of dispute resolution *should be used only where the parties agree to do so after a dispute arises.* (emphasis added).

Case Study: Virginia's Birth-Related Neurological Injury Compensation Fund

Virginia's Birth-Related Neurological Injury Compensation Program, in place for 15 years, is similar to what is being proposed for Massachusetts and provides some examples Massachusetts would face should this proposal be adopted.

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[52] Bill McKelway, "Panel Approves Bill on Birth Injuries; Would Expand Benefits and Notification Rights," *Richmond Times Dispatch*, Jan. 29, 2003.

[53] American Arbitration Assoc., American Bar Assoc. & American Medical Assoc., *Health Care Due Process Protocol* 15 (1998) (emphasis added).

[54] American Arbitration Assoc., *Health Care Policy Statement, at* http://www.adr.org/index2.1.jsp?JSPssid=16235&JSPsrc=upload/livesite/focusArea/Healthcare/HEALTH%20CARE%20POLICY%20STATEMENT.htm (last visited Nov. 17, 2003).

The Virginia program was established in the mid-1980s, during this country's last so-called "insurance crisis," as another misguided attempt to reduce skyrocketing insurance rates for doctors. Like the Massachusetts proposal, this program was set up as an injury compensation system for catastrophically injured newborns. It is the exclusive remedy for children delivered by a participating OB/GYNs and hospital. All claims go before an administrative panel, established within the workers comp. 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 been a tremendous failure on every level. It has hurt patients, has done nothing to help doctors with their insurance problems and has allowed the state to become a safe harbor for negligent and reckless doctors who should not be practicing medicine at all. Virginia's Joint Legislative Audit and Review Commission has suggested "abandoning or overhauling" the program[55] and "ridding the board of its heavy presence of medical professionals,"[56] and has found that the program could not be made fiscally sound.[57] In testimony before the Virginia Legislature, one parent called the 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."[58]

Although by no means an exhaustive list of the program's shortcomings, the following are some of its more notable problems:

- *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 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 seek to show he was negligent. He is facing a lawsuit,

[55] 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.
[56] Bill McKelway, "Brain-Injury Program's Outlook Dim; Cost Savings for Doctors Meant Less for Children," *Richmond Times Dispatch*, Nov. 16, 2002.
[57] Bill McKelway, "Brain-Injury Program's Outlook Dim; Cost Savings for Doctors Meant Less for Children," *Richmond Times Dispatch*, Nov. 16, 2002.
[58] Bill McKelway, "Danville Has High Birth-Injury Rate; Critics Say Virginia Law Shields Doctors from Lawsuits," *News Virginian*, June 1, 2003.

however, for a fourth case in which a woman giving birth bled to death after delivering a healthy baby.[59]

- *Has allowed Virginia to become a safe harbor for bad doctors*: National birth-injury experts have reportedly 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."[60]

- *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 out-dated criteria for assessing birth injuries. "Decisions in the [Virginia program's] cases can mean the difference between 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."[61]

- *Families of infants who died minutes after birth denied any compensation*: 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). That led to perverse situations such as a recent 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.[62]

- *Had not led to reduced malpractice insurance rates*: Doctors claim that the program has failed to protect them from unacceptable malpractice insurance rate increases.[63]

CONCLUSION

This proposal follows in the tradition of building a system based upon pleasing insurers rather than upon concern that those who are injured receive adequate compensation. The outline of this proposal shows little concern for what is best for patients or, particularly, the most severely injured patients.

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[59] Bill McKelway, "Danville Has High Birth-Injury Rate; Critics Say Virginia Law Shields Doctors from Lawsuits," *News Virginian*, June 1, 2003.
[60] Bill McKelway, "Brain-Injury Program's Outlook Dim; Cost Savings for Doctors Meant Less for Children," *Richmond Times Dispatch*, Nov. 16, 2002.
[61] Bill McKelway, "Old Rules Deny New Benefits; Children Rejected for Brain-Injury Program," *Richmond Times Dispatch*, June 5, 2003
[62] Bill McKelway, "Deceased Infant Put into Program; Ruling Blocks Suits Over Death of Baby," *Richmond Times Dispatch*, June 27, 2003
[63] *See, e.g.*, Novelda Sommers, "Peace of Mind is Pricey; Some Malpractice Insurance Soars," *Daily Press* (Newport News, VA), June 5, 2003.

One thing is for sure. This proposal will protect negligent or reckless health care providers from liability exposure, compel victims to resort to processes where more powerful interests prevail, and disrupt critical functions of the tort system, namely deterrence of unsafe practices, disclosure of dangers to a wider public, and authoritative expansions of respect for human life through written public precedents. And it will do nothing to help doctors' insurance problems. It is a terrible idea.