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**Before the New York City Council Committee on Health
and Committee on Women's Issues**

Oversight: Professional and Financial Barriers Facing Women's Health Care Providers.

January 31, 2012

I am Joanne Doroshow, President and Executive Director of the Center for Justice & Democracy at New York Law School, a national non-profit organization that is dedicated to educating the public about the importance of the civil justice system. I am also Co-Founder of Americans for Insurance Reform, a coalition of nearly 100 public interest groups from around the country that seeks better regulation of the property/casualty insurance industry. In addition, I served on the New York State Governor's Medical Malpractice Task Force in 2007 and 2008 and worked closely with insurance experts on the current insurance situation in New York. Since 2002, I have testified in Congress six times on medical malpractice insurance issues.

I can hardly express how shocked I was to read Proposed Res. No. 84-A. This resolution repeats, without substantiation, the same talking points we have seen for years regurgitated by the insurance and medical lobbies, as well as politicians like Rick Perry, George W. Bush, and Newt Gingrich. The goal of ending insurance price-gouging is something we have always supported. That is the entire purpose of our project, Americans for Insurance Reform. But this resolution is full of baseless claims and suggestions that are both offensive and false.

As a national consumer organization that has, for years, been fighting the insurance and medical lobbies who want to continually strip patients of their legal rights, we know exactly how issues of "access to care," such as those contained in Proposed Res. No. 84-A, tend to be discussed – couched in fear-mongering, not facts; anecdotes, not academic studies. Despite what is written in Proposed Res. No. 84-A, we hope the City Council rejects this approach.

Some physicians leave New York, many after just completing their training. In fact, in December 2009, the Center for Health Workforce (Center), part of the School of Public Health, University at Albany, State University of New York – an academic institution that monitors physician supply – published a paper called, "Less than Half of New Physicians Stay in New

York after Completing Training.”¹ But the single biggest reason these new doctors list for leaving New York is to be closer to their family, followed by better jobs and salary elsewhere. Of the reasons listed, “Cost of Malpractice Insurance” is practically dead last on the list of possible reasons for their leaving New York State. Even the general category “Other” outranks “Cost of Malpractice Insurance.” Notably, New York’s legal system is *not even listed* as a reason.

And when it comes to OB/GYNs, just looking at the last three “Physician Profile” reports from the Center it appears that the number of active patient care physicians practicing both obstetrics and gynecology in New York State has been completely stable (2,585 physicians in 2008; 2,554 physicians in 2009; 2,595 physicians in 2010) – all while birth rates are dropping in New York State.² Specifically, “demographic changes appear to be contributing to a reduction in demand for some obstetrical services in New York. Between 1995 and 2003, the total number of births declined in New York and at the same time, the number of hospital obstetrical days and hospital obstetrical beds also declined.”³

In terms of geographic regions, the Center also found that New York State as a whole had more than 55 OB/GYNs per 100,000 women of childbearing age in 2004 and that three regions had higher than the state average: Long Island (65.4 OB/GYNs), Hudson Valley (63.8 OB/GYNs) and New York City (59.4 OB/GYNs)⁴ – areas that tend to have the highest malpractice insurance rates.⁵ On the other hand, upstate regions showed a more dramatic decline – areas of the state with the cheapest malpractice insurance.

Attracting physicians to underserved areas is a long-standing problem having nothing to do with insurance rates but everything to do with lifestyle factors. Back in 1998, Oswego County reported great difficulty attracting physicians because of the “weather factor” and other lifestyle issues, including “boredom.” Another problem was the lack of professional jobs in the area for spouses. Officials also noted that “because the large hospitals offer the latest in technology and research, physicians are often lured to the major cities.”⁶ In 2009, another report showed more than twice the number of doctors per capita in White Plains, NY than Bakersfield, CA (despite California’s “cap” on compensation for injured patients).⁷ “Quality of life” issues explain this disparity:

¹ Armstrong DP, Forte GJ, and Moore J. *Less than Half of New Physicians Stay in New York after Completing Training*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany. December 2009.

² Martiniano R, Moore J, Armstrong D, Continelli T, McGinnis S, and Forte G. *Changing Practice Patterns of Obstetricians/Gynecologists in New York*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany. April 2006.

³ *Ibid.*

⁴ *Ibid.*

⁵ The industry’s underwriting process and models used to price certain specialties and geographic areas are secret. It is an area that demands more transparency (see later section.)

⁶ Carol Thompson, “Recruiting and Retaining Physicians Not an Easy Task,” *Oswego County Business*, April/May 1998.

⁷ Chris Baltimore, “SPECIAL REPORT: Are doctors what ails healthcare?” *Reuters*, Nov. 6, 2009, found at <http://www.reuters.com/article/companyNews/idUKTRE5A524720091106?pageNumber=1&virtualBrandChannel=11564>.

Doctors have been flocking to [the White Plains area] since the 1970s, drawn...[by] quality of life issues that any professional would consider when deciding where to live – climate, schools, and perhaps most importantly, income.

It's no mystery why doctors avoid Bakersfield. The summer heat is oppressive, the air quality is poor and the Valley has been pegged by congressional researchers as one of the nation's most depressed regions, on par with the Appalachia region stretching across West Virginia and other coal-mining states.

This finding is consistent with those of the Harvard School of Public Health⁸ (and many other researchers⁹), showing that the supply of OB/GYNs in a given state has no relationship to either doctors' malpractice premiums or a state's liability laws. Harvard researchers report:

⁸ Y. Tony Yang, David M. Studdert, S.V. Subramanian, Michelle M. Mello, "A Longitudinal Analysis of the Impact of Liability Pressure on the Supply of Obstetrician-Gynecologists," *Journal of Empirical Legal Studies*, Vol. 5, Issue 1, 21-53, March 2008.

⁹ Suzanne Batchelor, "Baby, I Lied," *The Texas Observer*, Oct. 19, 2007, found at <http://www.texasobserver.org/article.php?aid=2607> ("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."); Katherine Baicker, Amitabh Chandra, "The Effect of Malpractice Liability on the Delivery of Health Care," 24-25, Nat'l Bureau of Econ. Research, Working Paper, No. 10709, 2004, found at <http://www.dartmouth.edu/%7Ekbaicker/BaickerChandraMedMal.pdf> ("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."); Tim Bonfield, "Region Gains Doctors Despite Malpractice Bills," *The Cincinnati Inquirer*, October 10, 2004, found at http://www.enquirer.com/editions/2004/10/10/loc_doctor_day1.html ("[There are] more doctors in the state today than there were three years ago... [T]he data just doesn't translate into doctors leaving the state," says Larry Savage, president and chief executive of Humana Health Plan of Ohio."); Matt Richtel, "Young Doctors and Wish Lists: No Weekend Calls, No Beepers," *The New York Times*, January 7, 2004, found at <http://www.nytimes.com/2004/01/07/us/young-doctors-and-wish-lists-no-weekend-calls-no-beepers.html> ("Today's medical residents, half of them are women, are choosing specialties with what experts call a 'controllable lifestyle.'... 'I want to have a family. And when you work 80 or 90 hours a week, you can't even take care of yourself.'" said Dr. [Jennifer C.] Boldrick, explaining her decision to specialize in dermatology over plastic surgery."); "Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care," 16-17, General Accounting Office, GAO-03-836, Released August 29, 2003, found at <http://www.gao.gov/new.items/d03836.pdf> (To the extent that some physician supply problems existed, many explanations could be established "unrelated to malpractice," and that such problems "did not widely affect access to health care." Moreover, GAO found evidence that some members of the AMA and state medical societies had purposely left certain states for the purpose of manufacturing a physician supply problem as part of a larger campaign to pressure lawmakers into severely limiting injured patients' rights."); Eleanor D. Kinney, Malpractice Reform in the 1990s: Past Disappointments, Future Success?, 20 *J. Health Pol. Pol'y & L.* 99, 120 (1995) ("Despite anecdotal reports that favorable state tort environments with strict... tort and insurance reforms attract and retain physicians, no evidence suggests that states with strong... reforms have done so."); Eleanor D. Kinney & William P. Gronfein, Indiana's Malpractice System: No-Fault by Accident?, 54 *Law & Contemp. Probs.* 169, 188 (1991), cited in Marc Galanter, Real World Torts, 55 *Maryland L. Rev.* 1093, 1152-1153 (1996) (Indiana has "the most comprehensive and severe set of insurance and tort reforms in the nation." But the "data indicate that Indiana's population continues to have considerably lower per capita access to physicians than the national average.")

Our results suggest that most OB/GYNs do not respond to liability risk by relocating out of state or discontinuing their practice, and that tort reforms such as caps on noneconomic damages do not help states attract and retain high-risk specialties.

If the medical groups would like to discuss anecdotes or biased surveys of members, we can certainly point the Council to other, more constructive kinds of anecdotes – the thousands and thousands of individual stories of medical negligence in New York City and New York State. These injured patients are always the forgotten faces in the debate over medical malpractice. You see no reference to any of their stories in the Proposed Res. No. 84-A or any reference to the epidemic of medical negligence in this state. Every injured victim, or parent of a dead child, will tell you that they had *access* to medical care – their access was to inept physicians or dangerous hospitals. If given the choice, each would have gladly given up convenience for competence.

We urge the Council to firmly reject information from medical groups and their insurers about access that is grounded in anecdotes, secret information and fear. While I could provide entire papers about why virtually every premise of Proposed Res. No. 84-A is substantively wrong, I'll concentrate on a few areas where I believe City Council should focus: insurance transparency and failure of “caps” to fix insurance problems while having a devastating impact on patients, particularly women; medical errors and the impact on racial and ethnic minorities in New York; and litigation and patient safety-related issues. But before doing this, I would like to point out some background information about New York's medical malpractice insurance situation.

NEW YORK'S MEDICAL MALPRACTICE INSURANCE – RECENT HISTORY

In the mid-1980s, New York was one of the many states that succumbed to pressure from medical and insurance lobbies to restrict the rights of injured patients after being told by these lobbyists that this was the only way to reduce skyrocketing insurance rates for doctors. As a result, New York State enacted three out of four “medical liability reform” agenda items pushed by the corporate-backed American Tort Reform Association: a sliding scale limit on attorney's contingent fees; prohibition of lump sum compensation payments to victims; and abolition of the collateral source. These laws added to legal obstacles that New Yorkers already faced, which residents in most other states do not: a restrictive statute of limitations law that begins to run from the date of a patient's injury as opposed to its discovery; and an archaic “wrongful death” law dating from the 1800s that does not allow compensation for emotional loss of a child who is killed by medical malpractice.

These “tort reform” laws had such a significant impact on reducing medical malpractice payouts that the State, at the direction of Governor Pataki (and earlier Governor Mario Cuomo), appropriated close to a billion dollars from the reserves of the Medical Malpractice Insurance Association (MMIA) – established by the State as the medical malpractice insurer of last resort – to close gaps in the State's operating budget.

In 2001, the State finally dissolved MMIA, replacing it with the Medical Malpractice Insurance Plan (MMIP), an assigned risk plan in which all medical malpractice insurers participate. Unfortunately, because the State had drained MMIA's money, MMIP had accumulated a deficit

that, by law, had to be shouldered by the few companies selling malpractice insurance in the state.

In July 2007, Governor Spitzer established a Medical Malpractice Advisory Task Force to come up with ways to resolve this MMIP problem. I served on this Task Force. In October 2007, state insurance department representatives testified before the Task Force that the “frequency of medical malpractice insurance claims against doctors, nurses and other medical professionals are at a new low and has been stable for the third straight year. Severity is increasing at just 3 percent annually.” The Center for Health Workforce also testified that New York is “the most richly supplied state in the nation in terms of the number of physicians in practice relative to the state population.”¹⁰ So while it was clear that the MMIP problem had nothing to do with any lawsuit or claims “crisis” but rather with MMIA’s money being drained,¹¹ the hospital, medical and insurance lobbyists began using this process as an opportunity to argue for more limits on patients’ legal rights, using fabricated analysis and scoring by their own paid insurance firms, like Milliman, to justify their position.

Yet virtually all of their insurance data were secret. Our own studies showed great reason to be skeptical that the crisis was anywhere near what MLMIC and the state insurance department were claiming at the time. For example, the MMIP deficit was said to be \$1.5 to \$2 billion in 2007, but we said this was calculated by use of unknown data and assumptions including Incurred But Not Reported (IBNR) reserves, which are essentially guesses about what they might pay out in the future on claims they don’t even know about yet and tend to be highly exaggerated. (History shows that during certain parts of the insurance cycle – “hard markets” – insurers vastly overstate their IBNR losses by increasing reserves – money set aside to pay them – despite experiencing no increase in payouts or any trend suggesting large future payouts. This “over-reserving” seems often to be politically-inspired, used by insurers as a way to show poor income statements, which in turn is used to justify imposition of large premium increases.)

We recommended in 2007 that there was no need for quick action as, even if the deficit were real, insurers had large cash available in reserves – \$8 billion. ***We were right.*** A rate freeze for two years and only two small increases of 5% since, and the situation has now eased and stabilized. What’s more, according to MLMIC’s most recent annual report, the company has *released* over three-quarters of a billion dollars of loss and LAE (loss adjustment expense) reserves, a whopping \$788 million to be precise. So it appears that we were correct that reserves were excessive in 2007.

We also noted at that time that to properly analyze overall trends in frequency, severity and premiums – including by specialty and geographic area – we must have data from all carriers showing paid losses by quarter, number of doctors insured by quarter and number of paid claims by quarter. We never got these data, and we still do not have them.

¹⁰ Physician Supply and Demand Indicators in New York, 2000-2005: A Summary of Trends for 35 Medical Specialties. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany.

¹¹ See also, Public Citizen Study, “A Self-Inflicted Crisis: New York’s Medical Malpractice Insurance Troubles Caused by Flawed State Rate Setting and Raid on Rainy Day Fund” (November 2007).

NEW YORK STATE SUFFERS FROM AN EXTREME LACK OF DATA ON MEDICAL MALPRACTICE INSURANCE

When it comes to the insurance industry and claims data, New York State is one of the least transparent states in the nation. Even Texas has better disclosure laws than New York.¹² The impact of this goes far beyond simply harming public confidence in city and state government and major institutions. This secrecy also has serious public safety implications, since the public and lawmakers never learn the reason claims arise and are paid. Moreover, experience in states like Illinois¹³ shows how insurer reporting and transparency can result in significant enhancements to the insurance market, lower premiums, increased competition and other improvements that can benefit all health care professionals.

Late last year, eight health insurers in New York State, with 90 percent of the market of small group and individual insurance plans, formally ended their fight to keep secret documents supporting their requests for rate hikes. The companies said that “the filings were no longer due confidentiality under a ‘trade secrets’ exception to freedom of information laws.” As the *New York Times* noted, “Some of the insurers have argued that disclosure would hurt their competitive position, and that the filings were too technical to be understood by consumers.”¹⁴

While health insurers have now given up this argument and their fight to keep documents from public disclosure, the medical malpractice insurance carriers in New York State have not. Meanwhile, public officials are asked to make policy recommendations based on outlandishly inaccurate information that cannot be analyzed, if history is any guide. The following are some examples of the most critical medical malpractice insurance data needs in New York State:¹⁵

Full “closed claims” study for each med mal insurer for at least a ten-year period, and continuing on an ongoing basis.

- These data would be used to determine, at a minimum: (1) the major causes of New York medical malpractice claims; (2) causal factors that underlie trends in loss costs; and (3) ways to help physicians practice safer medicine.¹⁶
- We understand that DOH already collects some of this information. However, there are concerns about its completeness and the lack of analysis.

¹² See, e.g., <http://www.tmlt.org/newscenter/closedclaimstudies.html>.

¹³ “Illinois Department of Insurance Encourages Insurers to Comply with 2005 Medical Malpractice Reforms; Department observed increased competition, 10% decrease in premium paid since 2005 reforms,” February 20, 2010, found at http://www.insurance.illinois.gov/newsrsls/2010/02202010_a.asp

¹⁴ Nina Bernstein, “7 More Insurers End Objections on Rate Filings,” *New York Times*, October 27, 2011.

¹⁵ Based on Testimony of J. Robert Hunter, Director Of Insurance, Consumer Federation of America before the Medicaid Redesign Team Medical Malpractice Reform Working Group, October 27, 2011. Hunter is co-founder of Americans for Insurance Reform. He was formerly the Commissioner of Insurance for the State of Texas, the Federal Insurance Administrator under both Presidents Carter and Ford, and President and Founder of the National Insurance Consumer Organization.

¹⁶ See, e.g., <http://www.tmlt.org/newscenter/closedclaimstudies.html> (Texas); http://www.facs.org/fellows_info/bulletin/2007/griffen0107.pdf

- The State should invest sufficient resources to audit compliance with closed claim reporting requirements and create the analytic capacity to both track root causes over time and to develop and disseminate that information in ways that promote improvements in patient safety.
- There should be public access to closed claim information necessary for analytics and other research purposes.

Frequency and severity trends for the entire med mal industry and for each company, going back for at least six years, as well as going forward, including particular analysis of the Neurologically Impaired Infant Fund’s impact.

- Even before the NII Fund was created in 2011, all parties agreed that claims frequency had been down in New York for years. However, certain parties had been claiming that severity was increasing, *even though data from the state’s second largest insurer, Physicians Reciprocal Insurance (PRI) – which it was willing to share – shows that paid losses (“severity trend”) were at 2%, growing at a rate less than medical inflation.* The amount of severely contradictory information permeating this issue must be resolved.
- That said, the impact of the 2011 NII Fund on hospitals payouts is enormous and must be examined as well. The NII Fund established a new liability and compensation system for the families of newborns who suffer brain damage at birth due to negligence, to cover costs for their future medical care. This process, which denies such families the same kind of rights and recourse that every other negligence victim has in the state, is not a “no-fault” fund. The Fund kicks in after a jury verdict or settlement, in other words, *after* the family endured the time and expense of proving their case in court (or settled), and the health care provider was found negligent. It is also a reimbursement fund, so the family may only recover money after they have actually incurred expenses for their child’s care. In other words, the child and his/her family are forced to deal with a burdensome and humiliating struggle to get bills paid from an unaccountable state entity, adding additional burdens on families who already face unimaginable challenges caring for a profoundly disabled child. Clearly, despite their prior complaints about these cases, hospitals are now spending far less money compensating these victims.

Careful study of reserves (including “Incurred But Not Reported” claims or IBNR) of all New York State medical malpractice insurers.

- The study should include a review of Statutory Page 14s and full Schedule Ps, which must be made available from all insurers, including MMIP. Reserves in New York should also be compared to those of carriers in other states.
- Insurers estimate IBNR reserves, which are essentially guesses about what they might pay out in the future on claims they don’t even know about yet. At least as of 2008, reserves were remarkably high and likely excessive. As we noted earlier, according to MLMIC’s annual report, the company has recently released over three-quarters of a billion dollars of loss and Loss Adjustment Expense reserves, a whopping \$788 million to be precise, raising questions as to whether they have been excessive.

Analysis of the real financial status of MMIP, with full data disclosure; an annual statement should be required, going back to 2005.

- The current MMIP deficit is said to be in the \$470 million range, but data on how this figure was calculated are publicly unavailable as MMIP currently issues no annual statement. In fact, there is almost a complete lack of public data on MMIP. All we know for sure is the unreliability of the MMIP deficit figures over time.
- PRI says that the surplus deficit that appears on its books (as opposed to reserves, which are plentiful) is due primarily to MMIP and how it is carried on its books. Simply correcting how this figure is carried on the books of carriers could reduce this number significantly. Specifically, like the State Guarantee Fund, the expected payouts *in the near term* should be on the books of the carriers, not the expected payout in the infinite term, as it currently is.
- We also do not know if the reserves for MMIP are anywhere near accurate, since they are in a black box the public cannot see and analyze. If MLMIC, which administers MMIP, sets the reserves in MMIP the way they set them in their own books, it is certainly possible reserves are inflated. These data should be disclosed.

All recent rate filings (e.g., from 2005) – with full information, unrestricted by overbroad “trade secret” assertions – should be made available for study and analysis as they have in other states¹⁷ and by New York’s health insurers; there must be an analysis of rate comparisons between specialties, areas within New York State, areas with similar demographics in contiguous states and all other factors about the causes of higher medical malpractice insurance rates in New York.

- For example, per occupied bed costs in New York State are estimated by Zurich North American Insurance to be \$4,522, which is higher than most states. In addition, according to the U.S. census, New York ranks #3 in the nation in terms of the number of doctors per 100,000 population (392 while the U.S. figure is 267, or one and a half doctors in New York for every doctor in the nation), behind only Massachusetts and Maryland. The ranking of each of these states reflects that doctors are attracted to states with teaching hospitals, which also causes cost increases because of the use of cutting-edge technology. New York also has 30% higher inpatient day hospital utilization rates than the national average and 25% more outpatient visits, as well as higher income, higher medical care costs and higher Medicare costs than the nation. In addition, patient safety is problematic here and, as mentioned before, insurance reserves may be excessive compared to the rest of the country. Meanwhile, in terms of medical malpractice claims, “Inflation-adjusted payouts per doctor in New York State have been stable, have failed to increase in recent years, and are comparable to what they were in the early 1980s.”¹⁸ How all of these data factor into ratemaking is completely unavailable to lawmakers or the public.¹⁹

¹⁷ In California, for example, “All information provided to the commissioner pursuant to this article shall be available for public inspection.” Section 1861.07 of the CA Insurance Code.

¹⁸ Americans for Insurance Reform, “Medical Liability and Malpractice Insurance in New York State” (2011); <http://insurance-reform.org/AIRNYMRTF.pdf>.

¹⁹ Based on Testimony of J. Robert Hunter, Director Of Insurance, Consumer Federation of America before the

- It also should be noted that inflation-adjusted premiums per doctor in New York State are among the lowest they have been in over 30 years, comparable to what they were in the mid-1970s.²⁰ This should be examined as well.

In sum, it would be simply unforgivable for public officials to consider taking any action regarding med mal insurance – let alone stripping patients’ rights – without obtaining this basic information and opening it up to public inspection.

CAPS ON NON-ECONOMIC DAMAGES DO NOT SOLVE INSURANCE PROBLEMS – THEY ONLY DEVASTATE VICTIMS

Non-economic damages compensate injured patients for intangible but real “quality of life” injuries, like the loss of a reproductive system, permanent disability, disfigurement, trauma, loss of a limb, blindness or other physical impairment. As University of Buffalo Professor Lucinda Finley has written, “certain injuries that happen primarily to women are compensated predominantly or almost exclusively through noneconomic loss damages. These injuries include sexual or reproductive harm, pregnancy loss, and sexual assault injuries.”²¹ When President Clinton vetoed a products liability bill on May 2, 1996, he said, “The legislation would make it impossible for some people to recover fully for non-economic damages. This is especially unfair to senior citizens, women, children, who have few economic damages, and poor people, who may suffer grievously but, because their incomes are low, have few economic damages.”

Caps on non-economic damages not only discriminate, they also keep the most severely injured patients from getting adequate compensation,²² destroying yet another safety net for many vulnerable children and families. Moreover, according to Professor Finley, “[J]uries consistently award women more in noneconomic loss damages than men ... [A]ny cap on noneconomic loss damages will deprive women of a much greater proportion and amount of a jury award than men. *Noneconomic loss damage caps therefore amount to a form of discrimination against women and contribute to unequal access to justice or fair compensation for women.*”

Medicaid Redesign Team Medical Malpractice Reform Working Group, October 27, 2011. Hunter is co-founder of Americans for Insurance Reform. He was formerly the Commissioner of Insurance for the State of Texas, the Federal Insurance Administrator under both Presidents Carter and Ford, and President and Founder of the National Insurance Consumer Organization.

²⁰ Americans for Insurance Reform, “Medical Liability and Malpractice Insurance in New York State” (2011); <http://insurance-reform.org/AIRNYMRTF.pdf>.

²¹ Lucinda M. Finley, “The 2004 Randolph W. Thrower Symposium: The Future Of Tort Reform: Reforming The Remedy, Re-Balancing The Scales: Article: The Hidden Victims Of Tort Reform: Women, Children, And The Elderly, Emory Law Journal,” 53 Emory L.J. 1263, Summer, 2004.

²² A survey by the RAND Corporation found that the “most significant impact” of California's three decades-old \$250,000 cap “falls on patients and families who are severely injured or killed as a result of medical negligence or mistakes.” Source: “RAND Study: California Patients Killed or Maimed by Malpractice Lose Most Under Damage Caps,” Consumer Watchdog, July 13, 2004.

It should also be noted that racial and ethnic minorities receive inferior medical treatment by the health care industry and are being subjected to high rates of preventable medical errors.²³ As a result, limits on the rights of patients who have been killed or injured due to medical malpractice will disproportionately hurt racial and ethnic minorities as well. Complicating these issues is the fact that minorities are uninsured more often than non-Hispanic whites, a status that frequently results in less than adequate care and poor health consequences.

Despite the enormous hardships on innocent patients caused by “caps,” or the fact that they shift compensation burdens onto others (like taxpayers through Medicaid), insurers argue that caps are worth enacting since they will bring down insurance rates. This is absurd. This argument is based entirely upon a false predicate – that the U.S. civil justice system is to blame for insurance price-gouging. We have already shown this to be untrue for New York, but also, history repeatedly shows that capping damages will not lead to lower rates because what drives rate hikes has nothing to do with a state’s “tort” law. It is driven primarily by the insurance economic and underwriting cycle and remedies that do not specifically address this phenomenon through better regulation will fail to end price-gouging. Indeed, Proposed Res. No. 84-A entirely ignores the insurance industry’s major role in the pricing of medical malpractice insurance premiums – an industry that is also exempt from anti-trust laws under the federal McCarran-Ferguson Act. See much more in Americans for Insurance Reform’s study, *Repeat Offenders; How The Insurance Industry Manufactures Crises And Harms America*,²⁴ which exposes how the property/casualty insurance industry creates periodic insurance crises (“hard markets”). (Notably, contrary to Proposed Res. No. 84-A’s findings, the country is not in a “crisis” period. We have been in a soft insurance market since 2006; nationally, medical malpractice premiums, inflation-adjusted, are nearly the lowest they have been in over 30 years and low med mal rates are continuing.²⁵)

Maryland and Missouri are both examples of states that enacted severe caps on damages in the mid-1980s, only to be hit with huge rate hikes later.

- **Maryland.** In the mid-2000s (during the last “hard market”), Maryland was called an American Medical Association (AMA) “problem state”²⁶ and a “crisis state” according to the American College of Obstetricians and Gynecologists.²⁷ Yet Maryland had had a cap on non-economic damages since 1986, originally \$350,000 but later increased somewhat.²⁸ Despite the cap, the state experienced premiums that “rose by more than 70 percent in the last two years.”²⁹ This caused lawmakers to push for, once again, even

²³ See., Statement by Joanne Doroshov, Executive Director. Center for Justice & Democracy, Before the Assembly Standing Committee on Health Black, Puerto Rican and Hispanic Legislative Caucus, Health Care Disparities Between Minorities and Non-Minorities, April 22, 2004.

²⁴ See., <http://centerjd.org/content/study-repeat-offenders-how-insurance-industry-manufactures-crises-and-harms-america>

²⁵ Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care*, July 2009; <http://insurance-reform.org/pr/090722.html>

²⁶ AMA, *American’s Medical Liability Crisis: A National View*, http://www.ama-assn.org/ama1/pub/upload/mm/450/med_liab_20stat.pdf (June 2004).

²⁷ Mary Ellen Schneider, *Maryland: A State in 'Crisis' for Ob.Gyns*, OB/GYN NEWS, Oct. 15, 2004.

²⁸ MD. CODE ANN., CTS. & JUD. PROC. §11.108.

²⁹ James Dao, “A Push in States to Curb Malpractice Costs,” *New York Times*, Jan. 14, 2005.

more restrictions on patients' rights in a special session called by the Governor in 2004 ostensibly "to combat the high cost of malpractice insurance."³⁰

- **Missouri** was also identified by the AMA as a so-called "crisis state,"³¹ yet had had a cap on non-economic damages since 1986. The cap started at \$350,000 and was adjusted annually for inflation, reaching \$557,000 in 2003.³² "New medical malpractice claims dropped 14 percent in 2003 to what the [Missouri Department of Insurance] said was a record low, and total payouts to medical malpractice plaintiffs fell to \$93.5 million in 2003, a drop of about 21 percent from the previous year." And "the National Practitioner Data Bank, a federally mandated database of malpractice claims against physicians, found that the number of paid claims in Missouri fell by about 30 percent since 1991. The insurance department's database found that paid claims against physicians fell 42.3 percent during the same time period." *Yet doctors' malpractice insurance premiums rose by 121 percent between 2000 and 2003.*³³

Other experience – rate *hikes*, not decreases

- **Florida:** "When Gov. Jeb Bush and House Speaker Johnnie Byrd pushed through a sweeping medical malpractice overhaul bill . . . the two Republican leaders vowed in a joint statement that the bill would 'reduce ever-increasing insurance premiums for Florida's physicians . . . and increase physicians' access to affordable insurance coverage.'" But, insurers soon followed up with requests to increase premiums by as much as 45 percent.³⁴
- **Ohio:** Almost immediately after "tort reform" passed, all five major medical malpractice insurance companies in Ohio announced they would not reduce their rates. One insurance executive predicted his company would seek a 20 percent rate increase.³⁵
- **Oklahoma:** After "caps" passed in 2003, the third-largest medical malpractice insurer in the state raised its premiums 20 percent, followed by an outrageous 105 percent rate hike in 2004.³⁶ The largest insurance company, which is owned by the state medical association, requested an astounding 83 percent rate hike just after "tort reform" passed (which was approved on the condition it be phased in over three years).³⁷

³⁰ *Id.*

³¹ AMA, *American's Medical Liability Crisis: A National View*, http://www.ama-assn.org/ama1/pub/upload/mm/450/med_liab_20stat.pdf (June 2004).

³² Missouri Dep't of Ins., *Medical Malpractice Insurance in Missouri; The Current Difficulties in Perspective 7* (2003).

³³ "State report says malpractice claims fell," *Associated Press*, November 5, 2004.

³⁴ Julie Kay, "Medical Malpractice; Despite Legislation that Promised to Rein in Physicians' Insurance Premiums, Three Firms File for Big Rate Increases," *Palm Beach Daily Business Review*, Nov. 20, 2003.

³⁵ *E.g.* "Despite New Law, Insurance Companies Won't Lower Rates Right Away," *Associated Press*, Jan. 9, 2003.

³⁶ "Hike Approved for Premiums," *Daily Oklahoman*, April 8, 2004.

³⁷ *E.g.* "Oklahoma's Largest Medical-Liability Company Gets 83% Rate Increase Over Three Years," *BestWire*, Dec. 2, 2003.

- **Mississippi:** Four months after “caps” passed, investigative news articles reported that surgeons still could not find affordable insurance and that many Mississippi doctors were still limiting their practice or walking off the job in protest.³⁸
- **Nevada:** Within weeks of enactment of “caps” in the summer of 2002, two major insurance companies proclaimed that they would not reduce insurance rates for at least another year to two, if ever. The Doctors Company, a nationwide medical malpractice insurer, then filed for a 16.9 percent rate increase. Two other companies filed for 25 percent and 93 percent rate increases.³⁹
- **Texas:** During the 2003 campaign for Prop. 12 – the “tort reform” referendum that passed – ads promised rate cuts if caps were passed. Right after the referendum passed, major insurers requested rate hikes as high as 35 percent for doctors and 65 percent for hospitals.⁴⁰ In April 2004, after one insurer’s rate hike request was denied, it announced it was using a legal loophole to avoid state regulation and increase premiums 10 percent without approval.⁴¹ In a 2004 filing to the Texas Department of Insurance, GE Medical Protective revealed that the state’s non-economic damage cap would be responsible for no more than a 1 percent drop in losses.⁴²

Strong insurance regulatory laws – which New York does not have – are the only way to control insurance rates for doctors and hospitals.

There are only two states in the nation where it is possible to compare the impact on insurance rates of both “caps” on non-economic damages and strong insurance rate regulation (which New York State lacks): California and Illinois. The following describes the experience of both states. It is clear – caps do not solve doctors’ insurance problems. Rather, strong insurance regulatory laws are the only effective and fair way to control insurance rates for doctors and hospitals.

- **California - Caps:** In 1975, California enacted a severe \$250,000 cap on non-economic damages, the first in the nation. This cap has severely reduced the number of genuine malpractice cases brought in California.

The impact of this “cap” on cases and payouts has been clear, because caps on non-economic damages make many legitimate cases economically impossible for attorneys to bring: those involving seniors, low wage earners (including women who work inside the

³⁸ E.g. “Miss. Tort Reform Effort Falls Short,” *Commercial Appeal*, Feb. 18, 2003; Reed Branson, “Doctors In Oxford Shut, Cite Insurance,” *Commercial Appeal*, Feb. 14, 2003; Ben Bryant, “Tort Reform Has Done Little to Ease Malpractice Crisis,” *Biloxi Sun-Herald*, Feb. 2, 2003.

³⁹ E.g. Joelle Babula, “Medical Liability Company Requests Premium Increase,” *Las Vegas Review-Journal*, Feb. 11, 2003; Babula, “State Insurance Program Holds Off on Lowering Rates,” *Las Vegas Review-Journal*, Aug. 14, 2002.

⁴⁰ E.g. Darrin Schlegel, “Some Malpractice Rates to Rise Despite Prop. 12,” *Houston Chronicle*, Nov. 19, 2003; Darrin Schlegel, “Malpractice Insurer Fails in Bid for Rate Hike,” *Houston Chronicle*, Nov. 21, 2003; (Oct. 2003 rate filing from Texas Medical Liability Insurance Assoc. (JUA) to Texas Dep’t of Insurance).

⁴¹ “Insurer Switching to Unregulated Product to Raise Premiums,” *Assoc. Press*, April 10, 2004.

⁴² The GE Medical Protective filing can be found at: <http://www.consumerwatchdog.org/insurance/rp/rp004689.pdf>.

home), children and the poor, who are more likely to receive a greater percentage of their compensation in the form of non-economic damages.

Insurance defense attorney Robert Baker, who had defended malpractice suits for more than 20 years, told Congress in 1994, “As a result of the caps on damages, most of the exceedingly competent plaintiff’s lawyers in California simply will not handle a malpractice case ... There are entire categories of cases that have been eliminated since malpractice reform was implemented in California.”⁴³

Despite the reduction of legitimate cases (while deaths and injuries due to malpractice have increased), between 1975 and 1988, doctors’ premiums in California increased by 450 percent, rising faster than the national average.⁴⁴

Today, as a result of the cap, California’s medical malpractice insurance industry has become so bloated that “as little as 2 or 3 percent of premiums are used to pay claims” and “the state’s biggest medical malpractice insurer, Napa-based The Doctors Company, spent only 10 percent of the \$179 million collected in premiums on claims in 2009.” This led Insurance Commissioner Dave Jones to say that “insurers should reduce rates paid by doctors, surgeons, clinics and health providers while his staff scrutinizes the numbers.”⁴⁵

California - Insurance: In 1988, California voters passed a stringent insurance regulatory law, Proposition 103, which ordered a 20% rate rollback, forced companies to open their books and get approval for any rate change before it takes effect and allowed the public to intervene and challenge excessive rate increases.

During the period when every other state was experiencing skyrocketing medical malpractice rate hikes in the mid-2000s (during the last “hard market”), California’s regulatory law led to public hearings on rate requests by medical malpractice insurers in California, which resulted in rate hikes being lowered three times in two years,⁴⁶ saving doctors \$66 million.

Today, if the California medical malpractice insurance industry does not lower rates on its own, as the Insurance Commissioner has requested, Prop. 103 will allow the Commissioner to take action and do so.

⁴³ See, <http://www.multinationalmonitor.org/mm2003/032003/court.html>

⁴⁴ See, Consumer Watchdog, “Insurance Rate Regulation, Not Medical Liability Limits, Lowered California Malpractice Insurance Premiums,” <http://www.consumerwatchdog.org/newsrelease/house-republicans-have-their-talking-points-california-backwards-insurance-rate-regulati>, *How Insurance Reform Lowered Doctors’ Medical Malpractice Rates in California and How Malpractice Caps Failed* 1 (March 7, 2003), <http://www.consumerwatchdog.org/healthcare/rp/rp003103.pdf>.

⁴⁵ Shaya Tayefe Mohajer, “Calif regulator: Malpractice insurance too pricey,” *Associated Press*, February 17, 2011; http://www.mercurynews.com/news/ci_17414760?nclick_check=1

⁴⁶ Consumer Watchdog, “California Group Successfully Challenges 29.2% Rate Hike Proposed by California’s Ninth Largest Medical Malpractice Insurer; Proposition 103 Invoked to Slash Medical Protective Company’s Requested Increase by 60%,” Sep 16, 2004, <http://consumerwatchdog.org/insurance/pr/pr004625.php3>.

- **Illinois - Caps and Insurance:** In 2005, Illinois enacted a non-economic damages cap on compensation for injured patients (\$500,000 for doctors and \$1,000,000 for hospitals) and a very strong insurance regulatory law. In February 2010, the Illinois Supreme Court struck down the cap as unconstitutional. Because of a non-severability clause, the insurance regulatory law was struck down as well. However, in the five years these laws were in place, the following occurred:

Cap: The cap never really affected settlements or insurance rates in Illinois during the five years it existed. This was acknowledged in a May 2010 webinar sponsored by A.M. Best, where a Chicago-based insurance attorney said: “It may be headlines in other places but here in Cook County [Illinois] I think that the Supreme Court’s decision in *Lebron* was fully anticipated and discounted. None of the settlements that I’ve been involved in for the last couple of years paid the slightest attention to the caps anymore. There was almost a universal acceptance that it would be overturned by the Supreme Court. In fact it was overturned in Cook County two years ago. *Lebron* was a Cook County case going up, so the caps haven’t been law here for quite some time.”⁴⁷

Insurance: The strong insurance regulatory reforms *did* take effect and had an impact. In October 2006, the Illinois Division of Insurance announced that an Illinois malpractice insurer, Berkshire Hathaway’s MedPro, would be expanding its coverage and cutting premiums for doctors by more than 30 percent. According to state officials and the company itself, this was made possible ***because of new insurance regulatory law*** enacted by Illinois lawmakers in 2005, and expressly ***not the cap*** on compensation for patients.⁴⁸ The new law ***required malpractice insurers to disclose data on how to set their rates***. This, according to Michael McRaith, director of the state’s Division of Insurance, allowed MedPro to “set rates that are more competitive than they could have set before.”

In February 2010, the Illinois Division of Insurance released data showing that insurance regulation had greatly improved the medical malpractice insurance environment with expanded coverage and lower premiums for doctors.⁴⁹ Specifically, the Insurance Division said:

The 2005 Reform Laws imposed changes to the Illinois Insurance Code that improved insurer reporting and transparency requirements and enhanced the Department’s rate oversight authority. Since 2005, the Department has observed improvements in the medical malpractice insurance market. In particular, the Department observed:

⁴⁷ “State of the Medical Professional Liability Market,” *Best’s Review*, May 2010.

⁴⁸ Adam Jadhav, “Minor insurer is cutting malpractice rates for doctors,” *St. Louis Post-Dispatch*, October 13, 2006.

⁴⁹ “Illinois Department of Insurance Encourages Insurers to Comply with 2005 Medical Malpractice Reforms; Department observed increased competition, 10% decrease in premium paid since 2005 reforms,” February 20, 2010, found at http://www.insurance.illinois.gov/newsrsls/2010/02202010_a.asp

A decrease in medical malpractice premiums. Gross premium paid to medical malpractice insurers has declined from \$606,355,892 in 2005 to \$541,278,548 in 2008;

An increase in competition among companies offering medical malpractice insurance. In 2008, 19 companies offering coverage to physicians/surgeons each collected more than \$500,000 in premiums, an increase from 14 such companies in 2005; and

The entry into Illinois of new companies offering medical malpractice insurance. In 2008, five companies collected more than \$22,000,000 in combined physicians/surgeons premiums – and at least \$1,000,000 each in premiums – that did not offer medical malpractice insurance in 2005.”

Industry insiders have repeatedly admitted that capping damages will not lower insurance rates.

- **American Insurance Association:** “[T]he insurance industry never promised that tort reform would achieve specific premium savings.” (American Insurance Association Press Release, March 13, 2002)
- **Sherman Joyce, President, American Tort Reform Association:** “We wouldn’t tell you or anyone that the reason to pass tort reform would be to reduce insurance rates.” (*Liability Week*, July 19, 1999)
- **Victor Schwartz, General Counsel, American Tort Reform Association:** “[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and ‘I’ve never said that in 30 years.’” (*Business Insurance*, July 19, 1999)
- **Connecticut State Lawmaker:** “[T]he insurance industry now says [tort reform] measures will have no effect on insurance rates. We have been disappointed by the response of the insurance industry. The reforms we passed should have led to rate reductions because we made it more difficult to recover, or set limits on recovery. But this hasn’t happened.” (*UPI*, March 9, 1987)
- **State Farm Insurance Company (Kansas):** “[W]e believe the effect of tort reform on our book of business would be small. ... [T]he loss savings resulting from the non-economic cap will not exceed 1% of our total indemnity losses.....” (Letter from Robert J. Nagel, Assistant Vice President, State Filings Division, to Ray Rather, Kansas Insurance Department, Oct. 21, 1986, at 1-2.)
- **Aetna Casualty and Surety Co. (Florida):** After Florida enacted what Aetna Casualty and Surety Co. characterized as “full-fledged tort reform,” including a \$450,000 cap on non-economic damages, Aetna did a study of cases it had recently closed and concluded that Florida’s tort reforms would not effect Aetna’s rates. Aetna explained that “the review of the actual data submitted on these cases indicated no reduction of cost.” (Aetna

Casualty & Sur. Co., Commercial Ins. Div., Bodily Injury Claim Cost Impact of Florida Tort Law Change, at 2, Aug. 8, 1986)

- **Allstate Insurance Company (Washington State):** In asking for a 22% rate increase following passage of tort reform in Washington State, including a cap on all damage awards, the company said, “our proposed rate would not be measurably affected by the tort reform legislation.” (*Seattle Times*, July 1, 1986)
- **Great American West Insurance Company (Washington State):** After the 1986 Washington tort reforms, the Great American West Insurance Company said that on the basis of its own study, “it does not appear that the ‘tort reform’ law will serve to decrease our losses, but instead it potentially could increase our liability. We elect at this point, however, not to make an upward adjustment in the indications to reflect the impact of the ‘tort reform’ law.” (Letter from Kevin J. Kelley, Director of Actuarial, to Norman Figon, Rate Analyst, Washington Insurance Department, April 23, 1986, at 1)
- **Vanderbilt University:** A regression analysis conducted by Vanderbilt University economics professor Frank Sloan found that caps on economic damages enacted after the mid-1970s insurance crisis had no effect on insurance premiums. (Sloan, “State Responses to Malpractice Insurance Crisis of the 1970’s: An Empirical Assessment,” 9 *Journal of Health Politics, Policy & Law* 629-46 (1985))

ALARMING AMOUNTS OF MEDICAL MALPRACTICE IN NEW YORK; IMPACT ON RACIAL AND ETHNIC MINORITIES

It has been over a decade since the Institute of Medicine’s seminal study, *To Err is Human: Building a Safer Health System*,⁵⁰ was published, which found that between 44,000 and 98,000 patients are killed in hospitals each year due to medical errors. The statement in Proposed Res. No. 84-A that “90% of which are the result of failed systems and procedures rather than the negligence of individual practitioners” is a complete fabrication. IOM’S 98,000 figure was an extrapolation of the 1990 Harvard Medical Practice Study, which evaluated New York hospitals and used stringent criteria in choosing which adverse events to consider. The report notes, “Some maintain these extrapolations likely underestimate the occurrence of preventable adverse events because these studies: 1) considered only those patients whose injuries resulted in a specified level of harm; 2) imposed a high threshold to determine whether an adverse event was preventable or negligent (concurrence of two reviewers); and 3) included only errors that are documented in patient records.” In other words, the authors of the IOM study made special care to ensure that only incidents that were preventable or negligent were examined.

The Harvard Medical Practice Study actually found that in the year studied – 1984 – 6,895 patients died and 27,177 patients were injured due to negligence by doctors and hospitals. Moreover, of these deaths and injuries, “there were significant differences between hospitals that serve a predominantly minority population and other hospitals. That is, blacks were more likely

⁵⁰ Kohn, Corrigan and Donaldson, eds., *To Err Is Human: Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, D.C. (1999).

to be hospitalized at institutions with more AE's [adverse events] and higher rates of negligence."⁵¹

In 2002, the National Academy of Sciences Institute of Medicine (IOM) published its landmark study, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, which was conducted at the request of Congress. According to Dr. Brian Smedley, Director and Co-Editor of the report:

Importantly and perhaps foremost, we found that the health care playing field is not level. It is not level for minorities, many populations of color who, on average, receive a lower quality and intensity of health care. These disparities are found with consistency across disease areas, clinical services and settings.... Importantly, these disparities are associated with higher mortality among racial and ethnic minorities.⁵²

In *To Err is Human*, IOM reported on one study which found that “[m]ore than two-thirds (70 percent) of adverse events... were thought to be preventable, with the most common types of preventable errors being technical errors (44 percent), diagnosis (17 percent), failure to prevent injury (12 percent) and errors in the use of a drug (10 percent).”⁵³ Highly technical surgical specialties, such as cardiac surgery, contributed to higher rates of medical errors.⁵⁴

In *Unequal Treatment*, after reviewing the most recent data available, IOM researchers found racial and ethnic differences in cardiovascular care and significant racial differences in the receipt of appropriate cancer diagnostic tests, treatments and analgesics, all of which led to higher death rates among minorities.⁵⁵ Racial and ethnic disparities were also evident in diabetes care, end-stage renal disease and kidney transplantation, pediatric care, maternal and child health services and many surgical procedures.⁵⁶ In some cases, minorities were more likely to receive less desirable procedures, such as amputation, than non-Hispanic whites.⁵⁷

Other credible studies have uncovered evidence that race and ethnicity influence a patient's chance of receiving specific procedures and treatments. For example, according to the Agency for Healthcare Research and Quality (AHRQ), a division of the U.S. Department of Health and Human Services, the length of time between an abnormal screening mammogram and the follow-up diagnostic test to determine whether a woman has breast cancer is more than twice as long for Asian-American, African-American and Hispanic women as it is for white women.⁵⁸

⁵¹ Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990).

⁵² Testimony of Dr. Brian Smedley during hearing with U.S. Representative Eddie Bernice Johnson (D-TX.) and the Asian-Pacific-American and Hispanic Caucuses on Health Disparities, April 12, 2002.

⁵³ Kohn, Corrigan and Donaldson, eds., *To Err Is Human: Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, D.C. (1999), p. 30.

⁵⁴ *Ibid.*

⁵⁵ Smedley, Stith and Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002), Institute of Medicine, National Academy Press: Washington, D.C. (2002), p. 5.

⁵⁶ *Ibid* at 5-6.

⁵⁷ *Ibid.*

⁵⁸ Agency for Healthcare Research and Quality, “Addressing Racial and Ethnic Disparities in Health Care” (February 2000), found at <http://www.ahrq.gov/research/disparit.htm>.

Moreover, as discovered by AHRQ, relative to non-Hispanic whites, racial and ethnic minorities are less likely to receive appropriate cancer care, cardiac care, diabetes care, pediatric care and many surgical procedures.⁵⁹ In one AHRQ study, white patients were more likely than Hispanic and African-American patients to “receive invasive cardiac procedures in hospitals performing a high volume of such procedures, a factor strongly associated with the quality of cardiac care.”⁶⁰ In other words, white patients are more likely to be treated in hospitals with experienced surgeons who are less likely to commit errors.

Racial prejudice may influence how minorities are treated by the health care industry. IOM researchers discovered that stereotyping, biases and uncertainty might play a role in medical disparities. Data showed that one-half to three-quarters of white Americans believe that minorities – particularly African-Americans – are less intelligent, more prone to violence and prefer to live off welfare compared to whites.⁶¹ “In the United States, because of shared socialization influences,” says the IOM, “there is considerable empirical evidence that even well-meaning whites who are not overtly biased and who do not believe that they are prejudiced typically demonstrate unconscious implicit negative racial attitudes and stereotypes.”⁶² (This group of “well-meaning whites” necessarily includes white healthcare providers, who, according to the IOM, may fail to recognize manifestations of prejudice in their own behavior.⁶³)

It is clear that whatever the cause, racial and ethnic minorities are receiving inferior medical treatment by the health care industry and are being subjected to high rates of preventable medical errors.

Following the IOM study, several New York newspapers ran extensive series on the degree and cost of malpractice in New York. In March 2000, a *New York Daily News* week-long investigative series found that “hundreds of New York State doctors, dentists and podiatrists – ranging from modest practitioners to prominent surgeons – have amassed extensive hidden histories of malpractice yet continue to treat patients.” Moreover, “making even three malpractice payments is rare – only 1% of the nation’s doctors have crossed that line, according to the national database. But those doctors account for 24% – or \$5.6 billion – of the money paid to aggrieved patients.... The effect of failing to crackdown on the tiny percentage of doctors with the worst malpractice records is stunning, because they are a powerful driving force behind medical misfeasance nationwide.”⁶⁴

⁵⁹ Agency for Healthcare Research and Quality, “Fiscal Year 2003: Research on Health Care Costs, Quality of Outcomes (HCQO),” found at <http://www.ahrq.gov/about/cj2003/hcqo03d.htm>; Agency for Healthcare Research and Quality, “AHRQ Focus on Research: Disparities in Health Care” (March 2002), found at <http://www.ahrq.gov/news/focus/disparhc.htm>; Agency for Healthcare Research and Quality, “Addressing Racial and Ethnic Disparities in Health Care” (February 2000), found at <http://www.ahrq.gov/research/disparit.htm>.

⁶⁰ Agency for Healthcare Research and Quality, “Addressing Racial and Ethnic Disparities in Health Care” (February 2000), found at <http://www.ahrq.gov/research/disparit.htm>.

⁶¹ Smedley, Stith and Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Institute of Medicine, National Academy Press: Washington, D.C. (2002), p. 10.

⁶² *Ibid.*

⁶³ *Ibid.*

⁶⁴ Russ Buettner and William Sherman, “The 15 Most Sued Doctors In New York; Operating In The Dark,” *New York Daily News*, March 5, 2000.

These conclusions are similar to those found by Public Citizen’s Health Research Group, which found that just 7 percent of New York’s doctors are responsible for 68 percent of malpractice payouts, according to the group’s examination of National Practitioner Data Bank data.⁶⁵

Since then, the statistics have only gotten worse. According to a November 2010 study by the Office of Inspector General of the U.S. Department of Health and Human Services, about 1 in 7 hospital patients experience a medical error, 44 percent of which are *preventable*.⁶⁶ The study concludes, “Because many adverse events we identified were preventable, our study confirms the need and opportunity for hospitals to significantly reduce the incidence of events.”⁶⁷ In addition, the cost to Medicare of these errors was \$4.4 billion a year.⁶⁸ Moreover, it noted, “These Medicare cost estimates do not include additional costs required for follow-up care after the sample hospitalizations.”⁶⁹

Meanwhile, Public Citizen called the New York Department of Health’s record of disciplining clearly bad doctors “shameful.”⁷⁰ In 2007, they wrote:

Between September 1990 and December 2006, 6,186 New York doctors made two or more malpractice payments. For comparison purposes, that figure represents only 7.7 percent of the 80,681 licensed physicians in New York in the first half of 2007, and probably far less than 7.7 percent of doctors practicing in the time period. (New York almost certainly had significantly more than 80,681 licensed physicians since 1990 because the 2007 data represent only a snapshot in time.) But that small share of doctors was responsible for a whopping 71 percent of dollars paid out for medical malpractice in the time period. Barely one-in-twelve (8.5 percent) of physicians with two or more payments has experienced any license-related disciplinary actions by the state.

Just 3,052 physicians made three or more malpractice payments in the time-frame studied. Yet these physicians, who represent no more than 4 percent of the state’s doctors in the time period and likely significantly less than that, have been responsible for nearly half (49.6 percent) of dollars paid for malpractice incidents since 1991. Of these doctors, only 10.8 percent have received licensure actions. Even more troubling is the fact that less than a third (31.5 percent) of the doctors who made *ten or more* payments have had a reportable licensure disciplinary action.

For example:

⁶⁵ “Just 7 Percent of New York’s Doctors Are Responsible for Two-Thirds of Malpractice Payouts, Study Shows,” March 10, 2003.

⁶⁶ U.S. Department of Health and Human Services, Office of the Inspector General, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (November 2010), pp. i-ii, found at <http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf>.

⁶⁷ *Id* at iii.

⁶⁸ U.S. Department of Health and Human Services, Office of the Inspector General, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (November 2010), pp. i-ii, found at <http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf>.

⁶⁹ *Id* at ii-iii (emphasis in original).

⁷⁰ Public Citizen Study, “A Self-Inflicted Crisis: New York’s Medical Malpractice Insurance Troubles Caused by Flawed State Rate Setting and Raid on Rainy Day Fund” (November 2007).

Physician number 59877 made 14 payments totaling \$10.6 million between 1994 and 2005. These included three obstetrics payments totaling \$2.7 million for “failure to monitor” and a \$325,000 surgery-related payment for “wrong body part.”

Physician number 27991 made 12 payments totaling \$9.8 million between 1994 and 2006. These included nine obstetrics payments totaling \$8.8 million.

Physician number 118288 made nine payments totaling \$8.1 million between 1998 and 2005. Five of the payments were obstetrics-related. In 2003, the physician made a \$1.9 million payment for “improperly performed c-section.”

Physician number 25575 made nine payments totaling \$8 million between 1992 and 2005. All but one of the payments was obstetrics-related. The physician made five payments for \$4.3 million for “improper performance,” and one payment of \$995,000 for “improper choice of delivery method.”

Physician number 24027 made five payments between 1994 and 2004, totaling \$7.8 million, including 2 payments for “improper choice of delivery method” and one payment of \$5.3 million for “delay in performance.”

FEAR OF LITIGATION IS NOT THE MAIN REASON DOCTORS FAIL TO REPORT ERRORS

- A January 2012 report from the U.S. Department of Health and Human Services (HHS) found that massive error underreporting at hospitals is caused by widespread employee failure to recognize patient harm.⁷¹ According to the HHS Inspector General, “[T]he problem is that hospital employees do not recognize ‘what constitutes patient harm’ or do not realize that particular events harmed patients and should be reported. In some cases, he said, employees assumed someone else would report the episode, or they thought it was so common that it did not need to be reported, or ‘suspected that the events were isolated incidents unlikely to recur.’”⁷²
- According to a 2006 study by Dr. Thomas Gallagher, a University of Washington internal-medicine physician and co-author of two studies published in the *Archives of Internal Medicine*, “Comparisons of how Canadian and U.S. doctors disclose mistakes point to a ‘culture of medicine,’ not lawyers, for their behavior.”⁷³ In Canada, there are

⁷¹ Robert Pear, “Report Finds Most Errors at Hospitals Go Unreported,” *New York Times*, January 6, 2012, found at <http://www.nytimes.com/2012/01/06/health/study-of-medicare-patients-finds-most-hospital-errors-unreported.html> (citing U.S. Department of Health and Human Services, Office of the Inspector General, *Hospital Incident Reporting Systems Do Not Capture Most Patient Harm* (January 2012), found at <http://oig.hhs.gov/oei/reports/oei-06-09-00091.pdf>).

⁷² *Ibid.*

⁷³ Carol M. Ostrom, “Lawsuit fears aren’t reason for docs’ silence, studies say,” *Seattle Times*, August 17, 2006, found at http://seattletimes.nwsourc.com/html/health/2003204605_apologies17m.html (citing from Thomas Gallagher, M.D. et al, “Choosing your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients,” *Archives of Internal Medicine*, August 14, 2006).

no juries, non-economic awards are severely capped and “if patients lose their lawsuits, they have to pay the doctors’ legal bills...yet doctors are just as reluctant to fess up to mistakes.”⁷⁴ Moreover, “doctors’ thoughts on how likely they were to be sued didn’t affect their decisions to disclose errors.”⁷⁵ The authors believed “the main culprit is a ‘culture of medicine,’ which starts in medical school and instills a ‘culture of perfectionism’ that doesn’t train doctors to talk about mistakes.”⁷⁶

- Research by George J. Annas, J.D., M.P.H. “found that only one quarter of doctors disclosed errors to their patients,”⁷⁷ but “the result was not that much different in New Zealand, a country that has had no-fault malpractice insurance”⁷⁸ (*i.e.*, no litigation against doctors) for decades. In other words, “[t]here are many reasons why physicians do not report errors, including a general reluctance to communicate with patients and a fear of disciplinary action or a loss of position or privileges.”⁷⁹

FAR FROM BEING “BROKEN,” EXPERTS SAY THAT THE CURRENT MEDICAL MALPRACTICE SYSTEM WORKS

While hype about “out-of-control” verdicts and frivolous lawsuits tends to dominate discussion around this issue, the facts and objective studies tell a different story. For example, “[s]ome of the largest medical malpractice awards in New York that made national headlines ultimately resulted in settlements between 5 and 10 percent of the original jury verdict actually being paid.”⁸⁰

Last year, Americans for Insurance Reform produced a study called “Medical Liability and Malpractice Insurance in New York State,” which examined over 30 years of New York insurance data. AIR found, “Inflation-adjusted payouts per doctor in New York State have been stable, have failed to increase in recent years, and are comparable to what they were in the early 1980s.”⁸¹

In an October 2011 study, California State University, Northridge Economics Professor and Cato Institute Adjunct Scholar Shirley Svorny analyzed existing empirical data and found that the medical malpractice system works just as it should. As Svorny explained,

- “The medical malpractice system generally awards damages to victims of negligence and fails to reward meritless claims. Plaintiffs’ attorneys, paid on a contingency basis, filter

⁷⁴ *Ibid.*

⁷⁵ *Ibid.*

⁷⁶ *Ibid.*

⁷⁷ George J. Annas, J.D., M.P.H., “The Patient’s Right to Safety – Improving the Quality of Care through Litigation against Hospitals,” *New England Journal of Medicine*, May 11, 2006.

⁷⁸ *Ibid.*

⁷⁹ *Ibid.*

⁸⁰ Valerie P. Hans and Neil Vidmar, *American Juries: The Verdict*. Amherst, NY: Prometheus Books (2007) at 333.

⁸¹ See, <http://insurance-reform.org/AIRNYMRTF.pdf>.

out weak cases. Patients who file valid claims are likely to collect, generally through out-of-court settlements.”⁸²

- “The fact that settlement is common suggests courts are providing good signals as to when plaintiffs will prevail. Under these conditions, insurance companies assess the validity of claims and settle valid claims rather than go to court.”⁸³
- “Critics of the system point to the fact that many initial claims do not involve negligence. This can be explained by patients and their attorneys seeking to gather information about the level of negligence associated with an injury. Once discovery shows a small likelihood of success, many plaintiffs drop their claims.”⁸⁴
- “Critics of the medical malpractice system point to its high administrative costs. ... Yet, as economist Patricia Danzon observes, the bulk of administrative costs are limited to the small fraction of cases that go to court. Meanwhile, the deterrent effect influences all medical practice.”⁸⁵

Similarly, in its 2006 closed claims study, the Harvard School of Public Health reported that legitimate claims are being paid, non-legitimate claims are generally not being paid and “portraits of a malpractice system that is stricken with frivolous litigation are overblown.”⁸⁶ Among the researchers’ more significant findings:

- Sixty-three percent of the injuries were judged to be the result of error and most of those claims received compensation; on the other hand, most individuals whose claims did not involve errors or injuries received nothing.⁸⁷
- Eighty percent of claims involved injuries that caused significant or major disability or death.⁸⁸
- “The profile of non-error claims we observed does not square with the notion of opportunistic trial lawyers pursuing questionable lawsuits in circumstances in which their chances of winning are reasonable and prospective returns in the event of a win are high. Rather, our findings underscore how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information that litigation triggers.”⁸⁹

⁸² Shirley Svorny, “Could Mandatory Caps on Medical Malpractice Damages Harm Consumers?” *Cato Institute*, October 20, 2011 at 3, found at <http://www.cato.org/pubs/pas/pa685.pdf>.

⁸³ *Ibid.*

⁸⁴ *Ibid.*

⁸⁵ *Ibid.*

⁸⁶ David M. Studdert et al., “Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,” 354 *N Engl J Med* 2024, 2025, 2031(2006), found at <http://www.hsph.harvard.edu/faculty/michelle-mello/files/litigation.pdf>.

⁸⁷ *Id.* at 2027-2028.

⁸⁸ *Id.* at 2026.

⁸⁹ *Id.* at 2030-2031 (2006).

- “[D]isputing and paying for errors account for the lion’s share of malpractice costs.”⁹⁰
- “Previous research has established that the great majority of patients who sustain a medical injury as a result of negligence do not sue. ...[F]ailure to pay claims involving error adds to a larger phenomenon of underpayment generated by the vast number of negligent injuries that never surface as claims.”⁹¹

LITIGATION IMPROVES PATIENT SAFETY

David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law, and Charles Silver of the University of Texas at Austin School of Law, have researched and written extensively about medical malpractice.⁹² They confirm, “The field of surgical anesthesia, where anesthesiologists adopted practice guidelines to reduce deaths, injuries, claims and lawsuits, is a strong case in point. ... [T]wo major factors forced their hand: malpractice claims and negative publicity.... Anesthesiologists worked hard to protect patients *because* of malpractice exposure, not in spite of it.”⁹³ As Hyman and Silver explain, the reason why tort liability promotes patient safety is obvious: Providers are rational. When injuring patients becomes more expensive than not injuring them, providers will stop injuring patients.⁹⁴

In a breakthrough article by George J. Annas, J.D., M.P.H., the *New England Journal of Medicine* confirmed that litigation against hospitals improves the quality of care for patients. The author wrote, “In the absence of a comprehensive social insurance system, the patient’s right to safety can be enforced only by a legal claim against the hospital. ... [M]ore liability suits against hospitals may be necessary to motivate hospital boards to take patient safety more seriously.... Anesthesiologists were motivated by litigation to improve patient safety. As a result, this profession implemented 25-years-ago a program to make anesthesia safer for patients and as a result, the risk of death from anesthesia dropped from 1 in 5000 to about 1 in 250,000.”⁹⁵

Numerous other medical practices have been made safer only after the families of sick and injured patients filed lawsuits against those responsible. In addition to anesthesia procedures, these include catheter placements, drug prescriptions, hospital staffing levels, infection control, nursing home care and trauma care.⁹⁶ As a result of such lawsuits, the lives of countless other patients have been saved.

⁹⁰ *Id.* at 2031.

⁹¹ *Ibid.*

⁹² David A Hyman and Charles Silver, “The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?,” *90 Cornell L. Rev.* 893, 917 (2005).

⁹³ *Ibid.* at 920, 921.

⁹⁴ Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 47, citing David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It’s the Incentives, Stupid*, 59 *Vand. L. Rev.* 1085, 1131 (2006).

⁹⁵ George J. Annas, J.D., M.P.H., “The Patient’s Right to Safety – Improving the Quality of Care through Litigation against Hospitals,” *New England Journal of Medicine*, May 11, 2006.

⁹⁶ Meghan Mulligan & Emily Gottlieb, “Hospital and Medical Procedures,” *Lifesavers: CJ&D’s Guide to Lawsuits that Protect Us All*, Center for Justice & Democracy (2002) at A-36 *et seq.*, B-12 *et seq.*

The Harvard Medical Practice Study also acknowledged, “[T]he litigation system seems to protect many patients from being injured in the first place. And since prevention before the fact is generally preferable to compensation after the fact, the apparent injury prevention effect must be an important factor in the debate about the future of the malpractice litigation system.”⁹⁷

THE BEST WAY TO REDUCE MALPRACTICE LITIGATION IS TO REDUCE THE AMOUNT OF MALPRACTICE

NY Presbyterian Hospital-Weill Cornell Medical Center Obstetric Safety Initiative

- 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 2002.⁹⁸ 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 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 “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, they reported that “2009 compensation payment total constituted a 99.1% drop from the average 2003-2006 payments (from \$27,591,610 to \$ 250,000). The average yearly

⁹⁷ Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 47, citing Paul C. Weiler, Joseph P. Newhouse, & Howard H. Hiatt, *A Measure Of Malpractice: Medical Injury, Malpractice Litigation, And Patient Compensation* 133 (1993).

⁹⁸ Amos Grunebaum, MD; Frank Chervenak, MD; 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>

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.”

Beth Israel Deaconess Medical Center

I served on a New York State Medical Malpractice Task Force in 2007 and 2008, which among other things, discussed ways to improve patient safety as the best means of reducing 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 of the Harvard Medical School, was instructive. His presentation not only acknowledged the extent of birth injuries caused by OB error but also discussed the reasons for this and proven methods to correct the situation.

As did the NY Presbyterian Hospital-Weill Cornell Medical Center authors, Dr. Marcus also 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, neonatal encephalopathy. With crew resource management in place, there was 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 a certain birth-related injuries, as some doctors insist, clearly these kinds of statistics would not exist.⁹⁹

Rand Institute for Civil Justice

- In 2010, the Rand Institute for Civil Justice released a new report funded, in part, by insurance companies, which examined whether successful patient safety efforts lead to reductions in medical malpractice claims, since apparently no study had yet looked at this issue.¹⁰⁰ Rand looked at California hospitals from 2001 to 2005 and found that indeed it does. Specifically, the authors found:
 - [There is a] highly significant correlation between the frequency of adverse events and malpractice claims: On average, a county that shows a decrease of 10 adverse events in a given year would also see a decrease of 3.7 malpractice claims.

⁹⁹ 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 (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.”).

¹⁰⁰ Greenberg, Michael D., Amelia M. Haviland, J. Scott Ashwood and Regan Main. Is Better Patient Safety Associated with Less Malpractice Activity? Evidence from California. Santa Monica, CA: RAND Corporation, 2010. http://www.rand.org/pubs/technical_reports/TR824.

- We also found that the correlation held true when we conducted similar analyses for medical specialties—specifically, surgeons, nonsurgical physicians, and obstetrician/gynecologists (OB-GYNs). Nearly two-thirds of the variation in malpractice claiming against surgeons and nonsurgeons can be explained by changes in safety. The association is weaker for OB-GYNs, but still significant.
- These findings are consistent with the basic hypothesis that iatrogenic harms are a precursor to malpractice claims, such that modifying the frequency of medical injuries has an impact on the volume of litigation that spills out of them. Although this is an intuitive relationship, it is not one that has been well validated previously. It suggests that safety interventions that improve patient outcomes have the potential to reduce malpractice claiming, and in turn, malpractice pressure on providers.
- [N]ew safety interventions potentially can have positive effects on the volume of malpractice litigation—a desirable result to seek out, even beyond the immediate impact of medical injuries avoided.
- Presumably, the one thing that all parties to the debate can agree on is that reducing malpractice activity by reducing the number of iatrogenic injuries is a good idea. Arguments about the merits of statutory tort intervention will surely continue in the future, but to the extent that improved safety performance can be shown to have a demonstrable impact on malpractice claims, that offers another focal point for policymakers in seeking to address the malpractice crisis. Based on the results of the current study, we would suggest that that focal point may be more immediately relevant than has previously been recognized.

CONCLUSION

For many years, we have assisted families from around the nation who have traveled to Albany and Washington, D.C. to voice their strong opposition to bills and documents like Proposed Res. No. 84-A. These families are the forgotten faces in the debate over how to reduce health care and insurance costs, and I hope that, at some point, City Council decides to hear from them.

Dr. Lora Ellenson, a pathologist at NY Presbyterian Hospital-Weill Cornell Medical Center, is one. Her now 13-year-old son, Thomas, was brain-damaged from a birth injury due to negligence. She spoke to the *New York Daily News* last year¹⁰¹:

“My son cannot walk or talk. He is not able to carry out activities of daily living – eating, dressing, toileting, bathing – without constant assistance from an adult. He also needs a motorized wheelchair, a speech output device and a wheelchair-accessible van, just to name a few.”

¹⁰¹ Denis Hamill, “Doctor with disabled son is no fan of governor's plan to cap malpractice suits,” *New York Daily News*, March 13, 2011.

Had the Ellenson's not won a malpractice award well above the proposed \$250,000 she would have had to quit her job to stay home with her son every day.

“Even with all the support, my son will face huge challenges throughout his life including his ability to move freely in the everyday world, to have a profession, to build friendships. Many of the things created for nondisabled individuals will never be available to him – climbing simple stairs, eating with utensils, swimming at a beach, rearranging the covers on his bed....

“As a physician, I have also had to grapple with the implications for my profession. I have had to come face-to-face with the knowledge that mistakes are made. Like most physicians, I live with the reality that we might one day make an error and be sued. When that day comes, I will be grief-stricken, not because of the process – although I am sure that won't be pleasant – but due to the fact that I may have caused someone irreparable damage.

“My only hope is that the damaged person can get what they need to live in the best way that they are able. As a physician, I want to know that there will be compensation to rebuild a life that has been diminished. Yet, as a mother, I also know that no typical physician, nor the system within which they operate, can possibly understand the true depth of these mistakes.”

Meanwhile, New York's insurance laws do not force medical malpractice insurance companies to disclose even basic information to lawmakers or the public that could substantiate or refute their allegations about the financial health of the industry, why doctors are being charged certain premiums or the impact of New York's civil justice system. The need for data disclosure is urgent. We also believe the State Insurance Department must take a far more active role controlling insurance rates.

The state should also review its programs that help place physicians in underserved areas. New York has had a program to provide financial assistance to encourage physicians to practice in underserved areas. A review of this program must examine what reforms, or expansions, are needed.

History is clear on one thing, however: Taking away the rights of the most seriously injured New Yorkers has been and continues to be a failed public policy. Laws and proposals that increase the obstacles sick and injured patients face in the already difficult process of prevailing in court are certainly the wrong way to respond to the important problems that face this city and state. Our objectives should be deterring unsafe and substandard medical practices while safeguarding patients' rights. Indeed, our goal must be to reduce medical negligence. Moreover, effective insurance reforms are the only way to stop the insurance industry from abusing its enormous economic influence here, which it uses to promote a legislative agenda that bilks taxpayers and severely hurts New Yorkers.