



Center for Justice & Democracy
116 W. Illinois
Suite 5E
Chicago, IL 60610
Tel: 312.644.8442
Fax: 312.644.8443
centerjd@centerjd.org
<http://centerjd.org>

**TESTIMONY OF AMBER HARD
STAFF DIRECTOR, CENTER FOR JUSTICE & DEMOCRACY-ILLINOIS
BEFORE THE ILLINOIS SENATE JUDICIARY COMMITTEE**

Medical Liability Reform: Patients Come First

March 10, 2005

I am Amber Hard, Staff Director of the Center for Justice & Democracy-Illinois, a public interest organization that is dedicated to educating the public about the importance of the civil justice system.

I appreciate the opportunity to address the issue of medical malpractice. Today, I will present testimony about the problem of medical malpractice in Illinois including patient safety and the life-saving importance of preserving our civil justice system.

INTRODUCTION AND SUMMARY

Last month, victims of medical malpractice and their families came together in news conferences in Chicago and the Metro East to express their frustration at being left out of the malpractice debate in our state. This group shared their heart-wrenching stories of malpractice at the hands of health care providers they trusted, and called on insurance companies to stop blaming them for high malpractice premiums without providing all the evidence, such as the insurance data that is still closed to public review. The families that spoke last week are the forgotten faces in the debate over how to reduce skyrocketing insurance rates for some doctors, and I am glad that today, you will be able to hear from a few of them.

Last week, you heard from ISMIE Mutual and the health care industry. The proposal they emphasize is capping awards to victims of medical malpractice. We must remember that these caps apply across the board to all cases, not just “frivolous” cases. They apply no matter how much merit a case has, or the extent of the misconduct of the hospital or doctor. They apply regardless of the severity of the injury. Therefore, those with the most at stake in these proposals are the most catastrophically injured. In fact, a recent survey by the Rand Corporation found that the “most significant impact of California's 29 year old medical malpractice caps law [the same

caps that have been proposed in Springfield] falls on patients and families who are severely injured or killed as a result of medical negligence or mistakes.”¹

Moreover, their suggested cap undermines our constitutional right to trial by jury by limiting the power and authority of jurors to decide cases based on the facts presented to them. Statehouse politicians should not be making these decisions –juries should.

We must remember the problem that they’re asking us to solve: If doctors say they are leaving the profession or leaving certain areas of the state because they cannot afford their insurance premiums, then the solutions to those problems lie with the insurance industry – not with the legal system or patients. But we should not stop there, if we are committed to keeping doctors in rural and suburban Illinois, then we must look at ALL the problems facing doctors, not just insurance premiums. We should not ignore the role of quality of life issues, physician education and shrinking insurance and government reimbursements.

In fact, *USA Today* recently reported a nation-wide shortage of doctors. This shortage is attributed not to the legal system or lawsuits, but rather to public policy decisions that have been driven by incorrect predictions of a physician surplus. “In 1997, to save money and prevent a doctor glut, Congress capped the number of [medical] residents that Medicare will pay for at about 80,000 a year.” It also reported that “The United States stopped opening medical schools in the 1980s because of the predicted surplus of doctors.”²

Patient safety must come first. Their proposed legislation reduces the accountability of hospitals and doctors. This will hurt patient safety. Instead we should, for example, crack down on the small number of doctors responsible for most of the malpractice. This will reduce both incidents of malpractice and lawsuits. There are many other patient safety measures that the Senate should be exploring. But we must *protect* the legal system and make it accessible for everyone seeking justice, accountability and adequate compensation for devastating injuries or death.

THE REAL COSTS OF MALPRACTICE AND DEFENSIVE MEDICINE

Medical malpractice claims and premiums are each a tiny percentage of the total costs of health care in this country, and have been for years. Medical malpractice payouts are less than one percent of total U.S. health care costs. All “losses” (verdicts, settlements, legal fees, etc.) have stayed under one percent for the last 18 years. Moreover, medical malpractice premiums are less than one percent of total U.S. health care costs as well. Dropping for nearly two decades, malpractice premiums have stayed below one percent of health care costs.³

¹ See, “Rand Study: California Patients Killed or Maimed by Malpractice Lose Most Under Damage Caps,” Foundation for Taxpayer and Consumer Rights, July 13, 2004, <http://www.consumerwatchdog.org/healthcare/pr/pr004466.php3>

² Dennis Cauchon, “Medical miscalculation creates doctor shortage,” *USA Today*, March 3, 2005

³ See, Americans for Insurance Reform, “Think Malpractice is Driving Up Health Care Costs? Think Again,” <http://www.insurance-reform.org/pr/AIRhealthcosts.pdf>

What's more, as far as defensive medicine, studies consistently show that only a very small portion of health care costs result from this. According to the Congressional Budget Office (CBO,) "some so-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by the positive (albeit small) benefits to patients.... CBO believes that savings from reducing defensive medicine would be very small." CBO also found that limiting tort liability would have no significant impact on health care spending.⁴

Similarly, in 1994, the congressional Office of Technology Assessment (OTA) found that less than 8 percent of all diagnostic procedures are likely to be caused primarily by liability concerns. OTA found that most physicians who "order aggressive diagnostic procedures . . . do so primarily because they believe such procedures are medically indicated, not primarily because of concerns about liability." The effects of "tort reform" on defensive medicine "are likely to be small."⁵

Indeed, far more costly to all Americans than malpractice lawsuits is the cost of medical errors. Total national costs of negligence in hospitals alone (lost income, lost household production, disability, and health care costs) are estimated to be between \$17 billion and \$29 billion each year. Moreover, these figures vastly underestimate the magnitude of the problem since hospital patients represent only a small percentage of the total population at risk, and direct hospital costs are only a fraction of the total costs.⁶

In light of the fact that medical malpractice is the eighth leading cause of death in the United States, killing more people than breast cancer, AIDS and traffic deaths, medical malpractice insurance is an amazing value, covering all medical injuries for about one-half of one percent of health system costs. On the other hand, the cost of injuries due to medical errors is huge. If there is a cost problem, it is with the amount of malpractice itself.

"ACCESS" CRISIS OR A "MALPRACTICE" CRISIS?

We are here today because of a growing fear that doctors are ceasing practice in Illinois because of high malpractice premiums. Numerous studies reject the notion that there has been any widespread access problem due to doctors' malpractice insurance rates. Statewide, the number of doctors in Illinois has gone up in the past several years, according to the Illinois Department of Professional Regulation.⁷

A GAO study confirmed that problems with physician exodus 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

⁴ *Id.* at 6.

⁵ U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H-602 (1994).

⁶ Institute of Medicine, *To Err is Human: Building a Safer Health System*, 1999.

⁷ "More Docs in Illinois," *Crains Chicago Business*, July 5, 2004.

providers identified long-standing factors in addition to malpractice pressures that affected the availability of services.”⁸

In August, 2004, the National Bureau of Economic Research also found: “The fact that we see very little evidence of widespread physician exodus or dramatic increases in the use of defensive medicine in response to increases in state malpractice premiums places the more dire predictions of malpractice alarmists in doubt. The arguments that state tort reforms will avert local physician shortages or lead to greater efficiencies in care are not supported by our findings.”⁹

In order to best solve the problem of access to care in Illinois, it is important to understand the problem. If physician exodus in Illinois exists, as a state we must focus our attention on ways to retain doctors in rural Illinois, a “crisis” that cannot be solved by changing the legal system.

In any event, patient safety should be our first priority. Unfortunately, too little is being done to weed out the small number of doctors responsible for most malpractice. According to the National Practitioners Data Bank, set up by Congress to track malpractice payouts, 3.6% of doctors are responsible for 47% of all malpractice claims paid in Illinois.¹⁰ As the *New York Times* recently reported,

Experts retained by the Bush administration said on Tuesday that more effective disciplining of incompetent doctors could significantly alleviate the problem of medical malpractice litigation.

As President Bush prepared to head to Illinois on Wednesday to campaign for limits on malpractice lawsuits, the experts said that states should first identify those doctors most likely to make mistakes that injure patients and lead to lawsuits.

The administration recently commissioned a study by the University of Iowa and the Urban Institute to help state boards of medical examiners in disciplining doctors.

“There’s a need to protect the public from substandard performance by physicians,” said Josephine Gittler, a law professor at Iowa who supervised part of the study. “If you had more aggressive policing of incompetent physicians and more effective disciplining of doctors who engage in substandard practice, that could decrease the type of negligence that leads to malpractice suits.”

Randall R. Bovbjerg, a researcher at the Urban Institute, said, “If you take the worst performers out of practice, that will have an impact” on malpractice litigation.¹¹

Public Citizen’s Health Research Group has made similar findings for many years.¹² The group found that only one-half of 1 percent of 770,320 licensed medical doctors faces any serious state

⁸ *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, General Accounting Office, GAO-03-836, Released August 29, 2003, <http://www.gao.gov/new.items/d03836.pdf>.

⁹ <http://www.dartmouth.edu/~kbaicker/BaickerChandraMedMal.pdf>

¹⁰ National Practitioners Databank, *2002 Annual Report*

¹¹ Robert Pear, “Panel Seeks Better Disciplining of Doctors,” *New York Times*, January 5, 2005.

sanctions each year. “Too little discipline is still being done,” the report said. “2,696 total serious disciplinary actions a year, the number state medical boards took in 1999, is a pittance compared to the volume of injury and death of patients caused by negligence of doctors.... Though it has improved during the past 15 years, the nation’s system for protecting the public from medical incompetence and malfeasance is still far from adequate.”

Illinois consistently ranks in the bottom of Public Citizen’s reports. Since 1995, Illinois has never risen above 36th in the country for rates of doctor discipline. In fact, we have typically ranked in the low 40s.¹³ Illinois residents are not safer because doctors go unsanctioned. Without being able to rely on professional sanctions, Illinois residents are dependent on the courts to keep unsafe doctors out of business.

And let there be no doubt that deaths and injuries due to medical malpractice are substantial. In late 1999, the National Academy of Sciences Institute of Medicine (IOM) published *To Err is Human; Building a Safer Health System*. The study makes some striking findings about the poor safety record of U.S. hospitals due to medical errors.¹⁴ For example, between 44,000 and 98,000 deaths occur each year in U.S. hospitals due to medical errors, the higher figure extrapolated from the 1990 Harvard Medical Practice study of New York hospitals. Even using the lower figure, more people die due to medical errors than from motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).

Another Public Citizen study used the IOM report to estimate the state by state effects of malpractice. They estimate that between 1,942 and 4,325 preventable deaths occur due to medical errors each year in Illinois. That malpractice costs Illinois \$750 million to \$1.28 billion in lost income, lost household production, disability and health care costs, and the personal costs of care. In comparison, according to the National Association of Insurance Commissioners, Illinois doctors spent \$380 million on malpractice premiums.¹⁵ Illinois residents pay a much higher price for malpractice than doctors do for malpractice insurance.

A recent survey found, “[e]ighty percent of U.S. doctors and half of nurses surveyed said they had seen colleagues make mistakes, but only 10 percent ever spoke up.” Moreover, “fifty percent of nurses said they have colleagues who appear incompetent” and “[e]ighty-four percent of physicians and 62 percent of nurses and other clinical care providers have seen co-workers taking shortcuts that could be dangerous to patients.” Doctors and nurses do not talk about these problems because “people fear confrontation, lack time or feel it is not their job.”¹⁶

¹² See, e.g., Sidney Wolfe et al., *20,125 Questionable Doctors*, Public Citizen Health Research Group, Washington, DC (2000).

¹³ Sidney Wolf and Peter Lurie. *Ranking of State Medical Boards’ Serious Disciplinary Actions in 200*, Public Citizen Health Research Group 2004.

¹⁴ Kohn, Corrigan, Donaldson, Eds., *To Err is Human; Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, DC (1999).

¹⁵ Public Citizen Congress Watch, 2003

¹⁶ “Survey: 80 percent of doctors witness mistakes; But only 10 percent report errors or poor judgment,” *Reuters*, January 26, 2005. <http://www.msnbc.msn.com/id/6872715/>.

Furthermore, 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. Studies by the Institute of Medicine and the Agency for Health Care Research and Equality have shown that minorities are more likely to be treated in hospitals that are likely to commit errors and to have less desirable procedures performed than Caucasians. The studies are documented in The Center for Justice and Democracy's own "Tort Reform and Racial Prejudice" report.¹⁷

What may seem like a recent epidemic of medical malpractice is, unfortunately, nothing new. Consider that in 1985 the director of Maternal/Fetal Medicine at Pasadena's Huntington Memorial Hospital told the American College of Obstetrics and Gynecology: "The greatest cause of malpractice is malpractice. You must understand that some of the malpractice out there is so grievous, offensive and implausible as to beggar the imagination."¹⁸ This kind of information led *Business Week* to write in its August 3, 1987 issue, "So what can we do? Start by facing up to what the problem is not. It is not a malpractice insurance crisis. Nor, contrary to popular mythology, is the problem a lawsuit crisis. The real crisis is the degree of malpractice itself."¹⁹

THE IMPACT OF "TORT REFORM" ON INSURANCE RATES

What the Studies Show. Most studies reject the notion that enactment of caps on damages will lower insurance rates. Weiss Ratings, an independent insurance-rating agency, found that between 1991 and 2002, states with caps on noneconomic 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.²⁰

Researchers at the National Bureau of Economic Research recently found: "There is a fairly weak relationship between malpractice payments (for judgments and settlements) and premiums – both overall and by specialty." Also, "past and present malpractice payments do not seem to be the driving force behind increases in premiums. Premium growth may be affected by many factors beyond increases in payments, such as industry competition and the insurance underwriting cycle."²¹

And the GAO found that multiple factors are responsible for rate variations, stating "[m]ultiple factors have contributed to the recent increases in medical malpractice premium rates." GAO finds that "state laws and regulations unrelated to tort reform, such as premium rate regulations, vary widely and can influence premium rates" and that pricing decisions are affected by "income from investments, and other market conditions such as the level of market competition among insurers and their respective market shares." GAO concludes, "[w]e could not determine the

¹⁷ See, www.centerjd.org.

¹⁸ Letter from Ralph Nader to Florida Speaker Mills and Senate President Vogt (1988).

¹⁹ Christopher Farrell, "Let The Free Market End Malpractice Warfare," *Business Week*, August 3, 1987.

²⁰ Weiss Ratings, *Medical Malpractice Caps Fail to Prevent Premium Increases*,

http://weissratings.com/News/Ins_General/20030602pc.htm;

<http://www.weissratings.com/malpractice.asp>.

²¹ See, <http://www.dartmouth.edu/~kbaicker/BaickerChandraMedMal.pdf>

extent to which differences in premium rates and claims payments across states were attributed only to damage caps or also to these additional factors.”²²

Indeed, “tort reform” advocates have long rejected the notion that enactment of caps on damages would lower insurance rates. The American Insurance Association (AIA) and the American Tort Reform Association (ATRA) have admitted in published statements that lawmakers who enact “tort reforms” should not expect insurance rates to drop, most recently with the AIA’s March 13, 2002 statement, “[T]he insurance industry never promised that tort reform would achieve specific premium savings.”²³

Recent Experience With “Tort Reform”: Rate Hikes, not Decreases. In the midst of the last insurance “crisis” in the mid-1980s, state lawmakers enacted often severe tort restrictions on patients’ rights after being told this was how to reduce insurance rates. These laws had absolutely no impact on insurance rates. 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.²⁴

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 recently. For example, Maryland, an American Medical Association (AMA) “problem state”²⁵ and a “crisis state” according to the American College of Obstetricians and Gynecologists,²⁶ has had a cap on non-economic damages since 1986, originally \$350,000 but later increased somewhat.²⁷ Despite the cap, the state experienced premiums that “rose by more than 70 percent in the last two years.”²⁸ This caused the state to pass, once again, even more restrictions on patients’ rights in a special session called by the Governor in 2004 ostensibly “to combat the high cost of malpractice insurance.”²⁹

Missouri, identified by the AMA as a so-called “crisis state,”³⁰ has had a cap on non-economic damages since 1986. The cap started at \$350,000 and has been adjusted annually for inflation,

²² *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, General Accounting Office, GAO-03-836, Released August 29, 2003, pp. 34-35, 37.

<http://www.gao.gov/new.items/d03836.pdf>.

²³ See, <http://centerjd.org/air/pr/Quotes.pdf>

²⁴ Hunter, J. Robert, Joanne Doroshov, *Premium Deceit – the Failure of “Tort Reform” to Cut Insurance Prices*, Center for Justice & Democracy (1999).

²⁵ 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).

²⁶ Mary Ellen Schneider, *Maryland: A State in ‘Crisis’ for Ob.Gyns*, OB/GYN NEWS, Oct. 15, 2004.

²⁷ MD. CODE ANN., CTS. & JUD. PROC. §11.108.

²⁸ James Dao, “A Push in States to Curb Malpractice Costs,” *New York Times*, Jan. 14, 2005.

²⁹ *Id.*

³⁰ 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).

reaching \$557,000 in 2003.³¹ “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 2003.³²

In California, 13 years after the state’s severe \$250,000 cap on damages was enacted, “doctors’ premiums had increased by 450 percent and reached an all-time high in California.” But, in 1988 California voters passed a stringent insurance regulatory law, Proposition 103, which “reduced California doctors’ premiums by 20 per within three years,” and stabilized rates.³³ In the thirteen years after MICRA, but before the insurance reforms of Prop. 103, California medical malpractice premiums rose faster than the national average. In the twelve years after Prop. 103 (1988-2000), malpractice premiums dropped 8 percent in California, while nationally they were up 25 percent.³⁴ Moreover, the law has led to public hearings on recent rate requests by medical malpractice insurers in California, which resulted in rate hikes being lowered three times in the last two years.³⁵

Indeed, states that have recently tried to solve doctors’ insurance problems by ignoring the insurance industry’s role in creating this crisis and focusing only on taking away patients’ legal rights with caps on damages and other “tort reforms” have only seen insurers immediately come back for rate *hikes*, not decreases. For example:

Texas: During the 2003 campaign for Prop. 12, the “tort reform” referendum that passed, ads promised rate cuts if caps were passed. After the referendum passed, major insurers requested rate hikes as high as 35 percent for doctors and 65 percent for hospitals.³⁶ The insurance commissioner disallowed these. In April 2004, after one insurer’s rate hike request

³¹ Missouri Dep’t of Ins., *Medical Malpractice Insurance in Missouri; The Current Difficulties in Perspective 7* (2003).

³² “State report says malpractice claims fell,” *Associated Press*, November 5, 2004.

³³ Foundation for Taxpayer and Consumer Rights, *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>.

³⁴ Foundation for Taxpayer and Consumer Rights, *Insurance Regulation, Not Malpractice Caps, Stabilize Doctors’ Premiums*, <http://www.ftcr.org/healthcare/fs/fs003013.php3> (last visited Feb. 16, 2005).

³⁵ Foundation for Taxpayer and Consumer Rights, “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>.

³⁶ *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; (October 2003 rate filing from Texas Medical Liability Insurance Association (JUA) to Texas Department of Insurance).

was denied, it announced it was using a legal loophole to avoid state regulation and increase premiums 10 percent without approval.³⁷

Doctors have seen less than a 1.5% reduction in their premiums since 2003.³⁸ Only one company, Texas Medical Liability Insurance Association, has lowered rates, but its customers are still paying 130% more than they were 5 years ago.³⁹

And 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.⁴⁰

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.⁴¹

Oklahoma: After "tort reform" 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 2004.⁴² 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).⁴³

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.⁴⁴ A year later, "[e]xecutives from Ohio's top medical insurance companies said they don't expect to see malpractice premiums stabilize for several more years."⁴⁵

³⁷ "Insurer Switching to Unregulated Product to Raise Premiums," *Assoc. Press*, April 10, 2004.

³⁸ "Texas Medical Professional Liability, Quarterly Report to the Legislature, 3rd Quarter 2004, Table 1: Physicians, Surgeons, and Osteopaths," Texas Department of Insurance, Nov. 5, 2004.

³⁹ "Medical Malpractice Insurance: Overview and Discussion," Texas Department of Insurance, Feb. 12, 2003).

⁴⁰ The GE Medical Protective filing can be found at:

<http://www.consumerwatchdog.org/insurance/rp/rp004689.pdf>.

⁴¹ 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.

⁴² "Hike Approved for Premiums," *Daily Oklahoman*, April 8, 2004.

⁴³ E.g. "Oklahoma's Largest Medical-Liability Company Gets 83% Rate Increase Over Three Years," *BestWire*, Dec. 2, 2003.

⁴⁴ E.g. "Despite New Law, Insurance Companies Won't Lower Rates Right Away," *Associated Press*, Jan. 9, 2003.

⁴⁵ "Probe Targets Doctor Costs," *Marion Star*, April 20, 2004.

Mississippi: Four months after “tort reform” 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.⁴⁶

Nevada: Within weeks of enactment of “tort reform” 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 Doctor’s 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.⁴⁷

History is clear on this matter: legislative attempts to reduce insurance rates by taking away the rights of the most seriously injured in our society has been and continues to be a failed public policy.

LEGAL SYSTEM PROTECTS PATIENTS

The insurance industry continues to blame litigation costs for rising premiums. Yet, claims against doctors and hospitals nationwide have fallen 8.9 percent in the last year, according to the U.S. Department of Health and Human Services. In fact, claims have risen a steady 3 percent when adjusted for inflation, while rates have fluctuated wildly.⁴⁸

Rather than being the cause of our malpractice woes, the legal system plays an important role in protecting patients in the United States and Illinois. Patients’ access to the courts leads not only to justice for the injured party if they win, but also to investigations of bad doctors and safety improvements to the practice of medicine.

According to the previously quoted Public Citizen study, there are between 1,942 and 4,325 deaths each year in Illinois due to medical errors and many thousands of injuries. Most of these victims’ families never take legal action. According the National Practitioner Databank, there were only 503 paid claims due to malpractice (deaths and injuries) in Illinois in 2003. In fact, Illinois has had no more than 590 payments in a year since 1999 (the earliest year tracked.)⁴⁹ Remember that Illinois scores towards the bottom in disciplining doctors, so these suits have become the primary means of policing the industry.

Settlements and jury awards can lead to life saving changes in the practice of medicine. In a March 5, 1995 *New York Times* article, Dr. Wayne Cohen, then-medical director of Bronx

⁴⁶ 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.

⁴⁷ 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.

⁴⁸ Joseph B. Treaster and Joel Brinkley, “Behind Those Medical Malpractice Rates,” *The New York Times*, February 22, 2005.

⁴⁹ National Practitioners Databank, Annual Report 2002

Municipal Hospital, said, “The city was spending so much money defending obstetrics suits, they just made a decision that it would be cheaper to hire people who knew what they were doing.”⁵⁰ In a somewhat obscure way, Dr. Cohen actually heralded one of the most important functions of lawsuits and the civil justice system: deterring unsafe practices.

Numerous hospital and medical procedures have been made safer as a result of lawsuits. These include anesthesia procedures, catheter placements, drug prescriptions, hospital staffing levels, infection control, nursing home care and trauma care, all of which are documented in the Center for Justice & Democracy study, *Lifesavers: CJ&D’s Guide to Lawsuits that Protect Us All*.⁵¹

Examples include:

Infection Control

“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. ‘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.’ Source: Rosenfeld, Harvey, *Silent Violence, Silent Death*. Washington, DC: Essential Books (1994), pp 55-6.

Prescription Verification

When 41-year-old Vincent Gargano was diagnosed with testicular cancer in 1994, he was given a 90 to 95 percent chance of survival. On May 26, 1995, he entered the University of Chicago Hospitals to undergo his last phase of chemotherapy. For four consecutive days Gargano received a dosage that was four times the needed amount, a mistake that went undetected by at least one doctor, two pharmacists and four nurses until four overdoses had already been administered. Hospital records showed that the prescribing doctor wrote the incorrect dosage and that three registered nurses failed to double-check the prescription against the doctor’s original order. As a result, Gargano suffered hearing loss, severe kidney damage, festering sores and ultimately the pneumonia that caused his death the following month. The case settled for \$7.9 million. Sources: Berens, Michael J., “Problem nurses escape punishment; State agency often withholds key details of violations,” *Chicago Tribune*, September 12, 2000; “Notable settlement,” *National Law Journal*, November 8, 1999, citing *Gargano v. University of Chicago Hospitals*, 95 L 10088 (Cook County Cir. Ct., Illinois, settled October 7, 1999); “University hospital to pay \$7.9 million for fatal doses of chemotherapy,” *Associated Press*, October 8, 1999; “Cancer Patient Dies After Chemo Overdose,” *Legal Intelligencer*, June 16, 1995.

As a result of the settlement, the hospital implemented new policies to ensure that doctors and nurses better document and cross-check medication orders. Sources: Berens, Michael J. &

⁵⁰ Dean Baquet and Jane Fritsch, “New York’s Public Hospitals Fail, and Babies Are the Victims,” *New York Times*, March 5, 1995.

⁵¹ See, <http://www.centerjd.org/free/Lifesavers.pdf>.

Bruce Japsen, "140 Nurses' Aides Fired by U of C. Hospitals; Registered Nurses Fear Work Burden." *Chicago Tribune*, October 31, 2000; Berens, Michael J., "U. of C. To pay \$7.9 Million In Death of Cancer Patient," *Chicago Tribune*, October 8, 1999."

SIMPLE SOLUTIONS TO REDUCE MEDICAL ERRORS

- **Reduce continuous work schedules.** According to studies published in the October 28, 2004, issue of the *New England Journal of Medicine*, "The rate of serious medical errors committed by first-year doctors in training in two intensive care units (ICUs) at a Boston hospital fell significantly when traditional 30-hour-in-a-row extended work shifts were eliminated and when interns' continuous work schedule was limited to 16 hours, according to two complementary studies funded by the National Institute for Occupational Safety and Health (NIOSH) and the Agency for Healthcare Research (AHRQ). Interns made 36 percent more serious medical errors, including five times as many serious diagnostic errors, on the traditional schedule than on an intervention schedule that limited scheduled work shifts to 16 hours and reduced scheduled weekly work from approximately 80 hours to 63. The rate of serious medication errors was 21 percent greater on the traditional schedule than on the new schedule."⁵²
- **Better technology in hospitals to provide better care with greater consistency.** A handful of hospitals are starting to use technology to make prenatal care and delivery safer. These hospitals are using computer software that improves monitoring and treatment.⁵³
- **Safer RN staffing ratios.** A 2002 study in the *Journal of the American Medical Association* found that patients on surgical units with patient-to-nurse ratios of 8:1 were 30 percent more likely to die than those on surgical units with 4:1 ratios.⁵⁴
- **Give Illinois Department of Professional Regulation more inspectors.** Illinois law requires one inspector for every 5,000 doctors in the state. In comparison, Iowa has 9 inspectors for about 6,000 doctors. More inspectors mean that complaints can be investigated and resolved more quickly.
- **Require insurers to report all lawsuits to Illinois Medical Disciplinary Board.** Current law requires insurers to report only claims that result in payouts, resulting in a large lag time between the incident of alleged malpractice and notification. Iowa, for example, requires notification at the time the lawsuit is filed. Although notification might not lead to an investigation, it gives the State Board of Medical Examiners more information and lead time if a pattern of lawsuits should develop.

⁵² "Interns' Medical Errors Affected by Work Schedules," November 15, 2004, <http://www.insurancejournal.com/news/national/2004/11/15/47660.htm>

⁵³ Margaret Ramirez, "System Checks Steps in Care," *Newsday*, Oct. 7, 2003.

⁵⁴ L.H. Aiken et al., "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," 288 *JAMA* 1987 (Oct. 23/30, 2002).

REAL INSURANCE REFORMS

For medical malpractice insurers, high-pressure tactics have paid off and will pay off again unless Illinois takes responsible, remedial steps to reign in the power and control the abuses of insurance companies. Otherwise, we will never be able to deal systematically with the tactics of this industry, which consistently looks for scapegoats to cover up its own instability and mismanagement.

Recommended reforms include:

- **Rate approval.** Giving the Department of Financial and Professional Regulation Insurance Division the power to approve or deny rates based on actuarial data provided by companies. Although companies are required to file their rates with the Department, it has no authority to approve or deny them. This allows the insurers to charge whatever they want. In Washington State, for example, the Insurance Commission, after a thorough review of actuarial data, recently called for a premium refund to doctors because they had been overcharged.⁵⁵
- **Public scrutiny.** Require the Insurance Division to hold a public hearing when rate increases of 10% or more are requested. These hearing will allow the public, especially doctors, to scrutinize the ratemaking process and have input.
- **Increased disclosure of information.** The Acting Director of the Insurance Division, Deirdre Manna, testified on Tuesday that there are insurance companies looking to come to Illinois. What they need to come in, she said, was not caps on damages, but the actuarial data tables used by ISMIE to set rates. State law prohibits the Division from releasing that information.⁵⁶

CONCLUSION

There are numerous factors leading to a medical malpractice problem in Illinois. Of greatest concern should be the amount of malpractice itself. The goal of any committee looking into this issue should be to reduce medical errors, which in turn will lead to fewer lawsuits. Another cause, as you will hear in the testimony of Mr. Angoff, is the lack of insurance regulations in Illinois and the way insurers run their companies.

The evidence does not bear out industry claims that the problem is litigation. I urge this committee, as it examines the problems of and solutions to the malpractice problem in Illinois, to keep patient safety, consumer protection, and the constitution rights of their constituents as their first priorities.

⁵⁵ Thomas Shapley, "Gouging, numbers belie medical malpractice 'crisis' claims," Seattle Post-Intelligencer," March 6, 2005.

⁵⁶ Dierdre Manna, Acting Director, Illinois Department of Financial and Professional Regulation-Insurance Division, Hearing on Medical Malpractice Before the General Assembly House Judiciary Committee., 94th General Assembly (Ill. March 8, 2005)