

Patient Rights Aren't Bargaining Chips!

Health care reform is about making sure that every American has access to quality, low-cost healthcare, not about limiting the legal rights of innocent patients harmed by medical negligence. Americans should not have to relinquish their constitutionally protected 7th Amendment rights in order to gain access to quality healthcare.

- **Medical malpractice is about real people with real injuries.** The Institute of Medicine estimates that 98,000 people die each year in the US from preventable medical errors (the 6th leading cause of death in America). Rather than reforming the legal system that provides protections to these injured patients, we must focus on reforming the medical system to prevent these errors from ever occurring in the first place.
- **Taking away patient rights does not improve the quality of our health care system or produce cost savings.** Forty-six states have already enacted medical malpractice tort reform measures. Yet these legal restrictions have done nothing to improve our health care system, reduce costs, or help people harmed by medical malpractice.
- **Defensive medicine is a myth.** Both the GAO and CBO question the prevalence of defensive medicine, and have detailed how tampering with the legal system will save practically no money. So-called defensive medicine may be motivated more by the income it generates for than by liability concerns. Even officials from the American Medical Association have told GAO investigators that “defensive medicine...is difficult to measure.”

Medical Negligence - Preventable Medical Errors

As many as 98,000 Americans die each year as a result of preventable medical errors and thousands more sustain serious, debilitating injuries during the course of medical treatment. People have been led to believe that there are hundreds of thousands medical negligence lawsuits every year and only a handful of genuine medical errors. In reality, the reverse is true. There are very few medical negligence lawsuits, and hundreds of thousands people dying every year from preventable medical errors. As University of Pennsylvania law professor Tom Baker puts it, "We have an epidemic of medical malpractice, not of malpractice lawsuits."¹

Malpractice is Prevalent

- Preventable medical errors kill as many as 98,000 Americans each year. If the Centers for Disease Control and Prevention were to include preventable medical errors as a category, they would be the sixth leading cause of death in America.²
- The Institute for Healthcare Improvement estimates that there are 15 million incidents of medical harm each year.³

Claims Are Not Frivolous

- Researchers at the Harvard University School of Public Health have found that nearly all medical negligence claims are meritorious, with 97 percent of claims involving medical injury and 80 percent involving physical injuries resulting in major disability or death.⁴
- Only one in eight negligently injured patients file a malpractice claim.⁵

Leading Cause of Death In United States		
1.	Heart disease:	652,091
2.	Cancer:	559,312
3.	Stroke :	143,579
4.	Chronic lower respiratory diseases:	130,933
5.	Accidents (unintentional injuries):	117,809
Preventable Medical Errors		98,000
6.	Diabetes:	75,119
7.	Alzheimer's disease:	71,599
8.	Influenza/Pneumonia:	63,001
9.	Nephritis/Nephrosis:	43,901
10.	Septicemia:	34,136

¹ Tom Baker, *The Medical Malpractice Myth*, 2005.

² *Deaths/Mortality, 2005*, National Center for Health Care Statistics at the Centers for Disease Control, viewed at <http://www.cdc.gov/nchs/fastats/deaths.htm>.

³ *Institute for Healthcare Improvement: Campaign – FAQs*, Institute for Healthcare Improvement, <http://www.ihl.org/IHI/Programs/Campaign/Campaign.htm?TabId=6>.

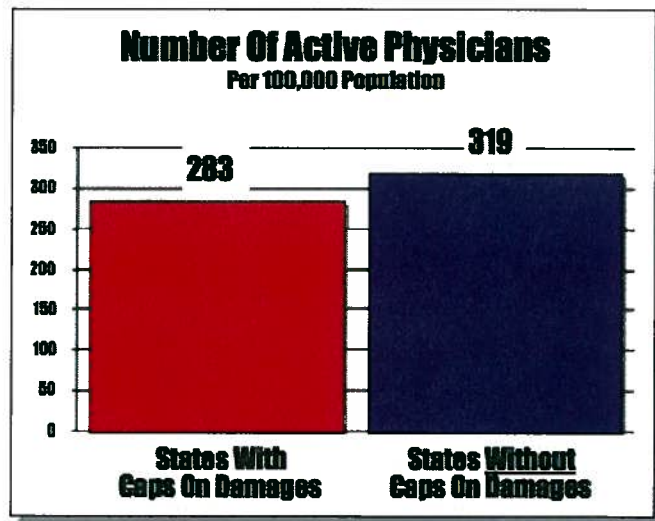
⁴ David M. Studdert, Michelle M. Mello, Atul A. Gawande, Tejal K. Ghandi, Allen Kachalia, Catherine Yoon, Ann Louise Puopolo, Troyen A. Brennan, *Claims, Errors and Compensation Payments in Medical Malpractice Litigation*, *New England Journal of Medicine*, 354;19, May 11, 2006.

⁵ *Harvard Medical Practice Study Group, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (Cambridge, Mass., Harvard University, 1990).

Medical Negligence - Physician Numbers

Contrary to reports of physicians fleeing the medical profession, recently released data from the American Medical Association (AMA) shows that the number of doctors has never been higher. Key findings from the AMA data include:

- **The number of doctors is increasing.**
The total number of physicians in the U.S. rose to yet another record high in 2007, the most recent year for which data is available. There were 941,304 physicians in the U.S. in 2007, nearly 20,000 more than the year before.¹
- **The number of doctors is increasing faster than population growth.**
The increase in physicians outpaced the increase in population once again. The number of physicians per 100,000 population is at an all-time high of 307. The increase of physician numbers compared to population growth has climbed steadily for decades. There are now twice as many physicians per 100,000 population as there were when the American Medical Association began tracking figures in the 1960s.
- **The number of physicians is increasing across the states.**
Despite the cries of physicians fleeing multiple states, the number of physicians has increased in every state. In addition, in the vast majority of states the increase in physicians either matched or outpaced population growth. *The only exceptions were four states with medical malpractice caps: Alaska, Georgia, Montana and Utah.*
- **The ratio of doctors to population is higher in states WITHOUT caps.**
The number of physicians per 100,000 population is significantly higher in states WITHOUT caps (319 v. 283).



¹ All figures were derived from the American Medical Association's own numbers (Physician Characteristics and Distribution in the U.S., Various Editions).

Medical Negligence - Defensive Medicine

Researchers have consistently refuted the idea that eliminating “defensive medicine” would result in significant health care cost savings. Some researchers even suggest “defensive medicine” may not be as prevalent as tort reformers suggest, and may be motivated not by liability concerns but by the desire to generate more income.

Government researchers question the prevalence of defensive medicine.

- A 2008 report released by the Congressional Budget Office (CBO) notes that the evidence on defensive medicine *“is not conclusive.”*¹
- The Government Accountability Office (GAO) has issued similar statements, saying, *“the overall prevalence and costs of [defensive medicine] have not been reliably measured. Studies designed to measure physicians’ defensive medicine practices examined physician behavior in specific clinical situations, such as treating elderly Medicare patients with certain heart conditions. Given their limited scope, the study results cannot be generalized to estimate the extent and cost of defensive medicine practices across the health care system.”*²
- The GAO reported that even “officials from AMA [American Medical Association] and several medical, hospital, and nursing home associations...told us that defensive medicine exists to some degree, but that it is difficult to measure.”³
- Doctors may not practice as defensively as they believe. One government agency found that doctors chose not to order any tests or diagnostic procedures 95 percent of the time. Doctors who ordered tests almost always did so because of medical indications, and only one half of 1 percent of all cases involved doctors who ordered tests due solely to malpractice concerns.⁴

Eliminating so-called defensive medicine would not reduce health care costs.

- Multiple CBO and GAO studies have concluded that eliminating defensive medicine would have only a minimal effect on reducing overall health care costs.
- The CBO believes that “savings from reducing defensive medicine would be very small.”⁵ A 2008 CBO report also notes that *“whether limits on malpractice torts have an impact on the practice of medicine has been subject to some debate.”*⁶

Doctors may actually practice “defensively” because it generates more income.

- According to the 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.”

- Health officials interviewed by the GAO cited “revenue-enhancing motives” as a reason for utilizing diagnostic tests and procedures.⁷
- When asked whether lawsuits increased health care costs, a general surgeon from McAllen, Texas (the most expensive health care market in the country) responded, ‘We all know these arguments [malpractice arguments] are bull****. There is overutilization here, pure and simple.’ Doctors, he said, were racking up charges with extra tests, services, and procedures.”⁸
- In Florida, for example, the majority of diagnostic-imaging centers and clinical labs are owned by physicians. Health officials in the state found that owning such facilities and ordering additional tests has provided a lucrative stream of income to physicians. Federal law now prohibits the referral of Medicare patients to certain physician-owned facilities, many of which charge double the amount in lab fees.⁹

Real health care savings could be achieved by reducing medical errors.

- Congress should focus its efforts on reducing medical errors, which the Institute of Medicine estimates causes as many as 98,000 American deaths each year. The costs associated with these errors are thought to be as high as \$29 billion annually.¹⁰

¹ Congressional Budget Office, *Budget Options, Volume I, Health Care*, 21, Dec. 2008.

² Government Accountability Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, September 29, 2003.

³ Government Accountability Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, September 29, 2003.

⁴ Alexee Deep Conroy, *Lessons Learned from the ‘Laboratories of Democracy’: A Critique of Federal Medical Liability Reform*,” CORNELL LAW REVIEW 1159, 1176 (2006).

⁵ Congressional Budget Office, *Limiting Tort Liability for Medical Malpractice*, January 8, 2004.

⁶ Congressional Budget Office, *Budget Options, Volume I, Health Care*, 21, Dec. 2008.

⁷ Government Accountability Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, September 29, 2003.

⁸ Atule Gawande, *The Cost Conundrum*, THE NEW YORKER, June 6, 2009.

⁹ Janice Castro, *Cover Story Condition: Critical*, TIME, June 24, 2001; See also John K. Iglehart, “The Emergence of Physician-Owned Specialty Hospitals,” *New England Journal Of Medicine*, 2006.

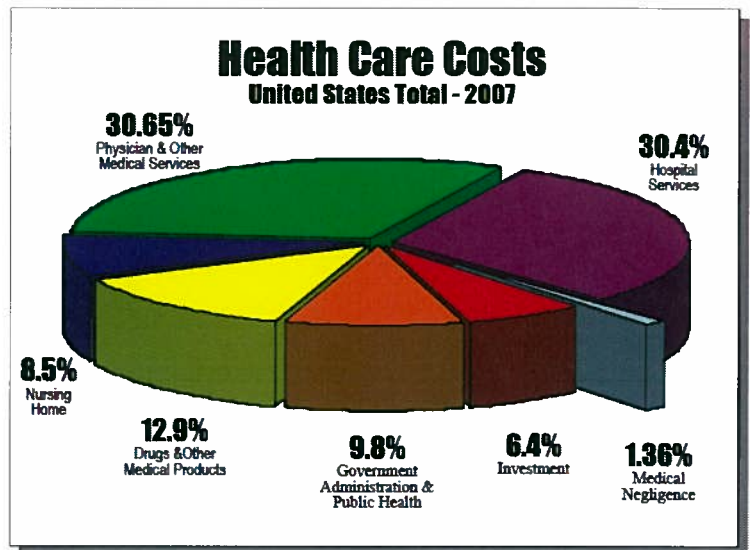
¹⁰ *To Err Is Human: Building a Safer Health Care System*, Institute of Medicine, 2000.

Medical Negligence - Health Care Costs

The United States spent over \$2.2 trillion on health care in 2007 and the costs continue to rise. While many people blame lawsuits for driving up the cost of health care, the reality is that the costs associated with the medical negligence system account for less than 1.5 percent of all health care spending. Focusing on reducing medical errors would be a far more effective way to lower costs and improve health care quality than eliminating the right of injured patients to seek justice.

Costs associated with medical negligence are only a very small portion of health care spending.

- The Congressional Budget Office (CBO) found that “even a reduction of 25 percent to 30 percent in malpractice costs would lower health care costs by only about 0.4 percent to 0.5 percent, and the likely effect on health insurance premiums would be comparably small.”¹
- In 2008, the agency reaffirmed its earlier findings, reporting that “the effect [of tort limits] would be relatively small— less than 0.5 percent of total health care spending.”²



Medical errors add billions to the cost of health care each year.

- Preventable medical errors kill as many as 98,000 Americans each year at a cost of \$29 billion.³
- Medication errors cause 7,000 deaths each year. The 1.5 million preventable adverse drug events that occur annually lead to \$3.5 billion in excess costs.⁴
- Hospital-acquired infections kill 90,000 patients each year at a cost of up to \$4.5 billion.⁵

¹ *Limiting Tort Liability for Medical Malpractice*, Congressional Budget Office, January 8, 2004.

² *Budget Options Volume 1 Health Care*, Congressional Budget Office, December 2008

³ *To Err Is Human: Building a Safer Health System*, Institute of Medicine, 1999.

⁴ *Preventing Medication Errors*, Report Brief, Institute of Medicine, July 2006.

⁵ Centers for Disease Control and Prevention, <http://www.cdc.gov/ncidod/dhqp/healthDis.html>

Medical Negligence – Premiums and Tort Reform

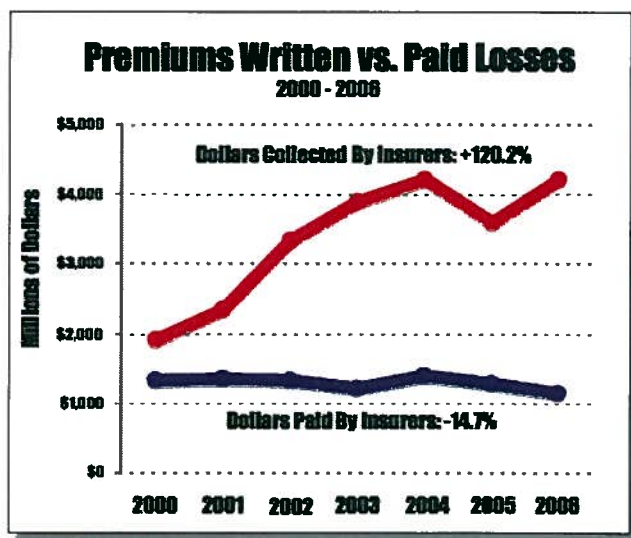
Empirical research across the board has found that there is little correlation between malpractice payouts and malpractice premiums. *Tort reform, in fact, does nothing but increase insurance company profits.*

Premium Hikes Have No Basis in Claim Outcomes. Empirical research into closed medical negligence claims has found that claims have no relationship to the premiums insurers charge doctors.

- One such study by researchers at the University of Texas, Columbia University and the University of Illinois based on closed claims compiled by the Texas Department of Insurance concluded that *“the rapid changes in insurance premiums that sparked the crisis appear to reflect insurance market dynamics, largely disconnected from claim outcomes.”*¹
- Researchers from the National Bureau of Economic Research came to the same conclusion, stating, *“increases in malpractice payments made on behalf of physicians do not seem to be the driving force behind increases in premiums.”*²
- A comprehensive analysis of insurance industry expenditures by Americans for Insurance Reform (AIR) likewise found no relationship between insurer payouts and premiums. AIR concluded, *“Not only was there no “explosion” in lawsuits, jury awards or any tort system costs to justify the astronomical premium increases that doctors have been charged in recent years. These rate increases were rather driven by the economic cycle of the insurance industry, driven by declining interest rates and investments.”*³ Instead, market dynamics, such as the fluctuation of investment income according to interest rate swings, were the sole cause of increased premiums.

Stable Claims but Rising Premiums. The conclusion of much of the empirical research is that even if tort reform saves insurance companies money, those savings are not passed on in the form of lower physician premiums or health care costs.

- A study of the leading medical malpractice insurance companies’ financial statements by former Missouri Insurance Commissioner Jay Angoff found that these insurers artificially raised doctors’ premiums and misled the public about the nature of medical negligence claims.⁴
- According to the study, the amount the leading malpractice insurers projected they would pay out in claims in the future declined; the amount they actually paid out in claims declined;



– “No Basis for High Insurance Rates,” Jay Angoff, May 2007

and their surplus—the extra cushion they have accumulated over and above the amount they have set aside to pay claims in the future—increased to an all-time high—five times the state minimum surplus for insurer stability.

¹ Bernard Black, Charles Silver, David A. Hyman, and William M. Sage, *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002*, *Journal of Empirical Legal Studies*, 2005.

² Katherine Baicker and Amitabh Chandra, *The Effect of Malpractice Liability on the Delivery of Health Care*, National Bureau of Economic Research, Working Paper, 10709, 2004.

³ Americans for Insurance Reform, *supra* note 39.

⁴ Jay Angoff, *No Basis for High Insurance Rates*, May 2007,

http://www.justice.org/resources/No_Basis_for_High_Insurance_Rates_2007.pdf

Medical Negligence - Physicians and Premiums

Empirical research across the board has found that there is no connection between medical malpractice premiums and physician supply. In fact, malpractice premiums have stayed relatively stable, while falling revenues has been the biggest factor pressuring physicians' incomes.

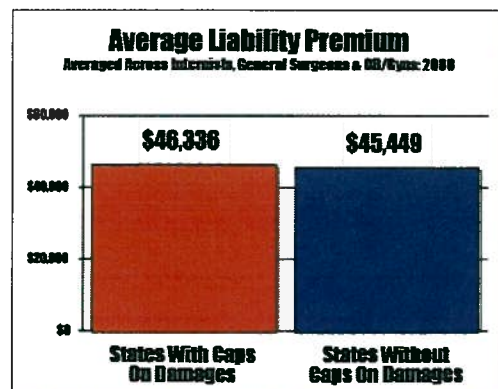
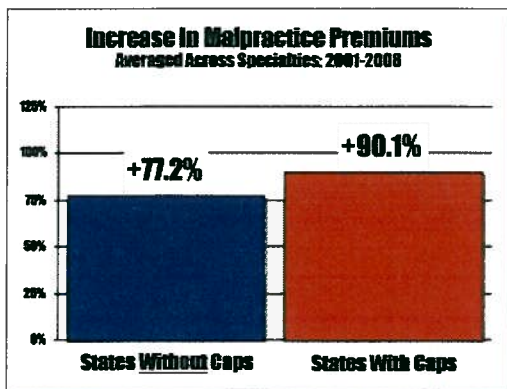
Physician Supply Unconnected to Physicians' Premiums

Empirical research has found that physician supply is not connected to insurance premiums. Researchers at the National Bureau of Economic Research (NBER) for instance found that increases in medical negligence costs did not have an effect on the size of physician workforces, and concluded, "*The arguments that state tort reforms will avert local physician shortages or lead to greater efficiencies in care are not supported by our findings.*"¹

A study of Pennsylvania physicians by Mello and colleagues found that the number of physicians leaving their practices were similar both before and during the "malpractice crisis."² That finding came in contrast to the authors' own survey of physicians. While 43 percent of high-risk specialists told the authors that they would restrict or eliminate services, only three percent actually did.

Similarly, a comprehensive study of the number of OB/GYNs in the United States over a 10-year period conducted by researchers from Harvard, George Mason, and the University of Melbourne, Australia, found that there was no connection between supply of OB/GYNs and premiums or tort reforms. The authors concluded, "*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 specialists.*"³

Data derived from Medical Liability Monitor's annual rate survey shows that premiums in states with caps actually grew more over the period of the medical negligence crisis than states without caps.⁴ States without caps experienced a 77 percent increase in premiums, but states with caps experienced a 90 percent increase. States that enacted caps during this period saw even bigger premium increases of 129 percent. The average premium in states with caps was two percent higher than in states without caps.



Physician Practice Expenses and Income

One reason the empirical research has found no connection between physician supply and insurance premiums is that malpractice insurance premiums are not nearly as excessive as often portrayed. In fact, according to the AMA's own data, medical malpractice premiums increased only slightly in the 30 years between 1970 and 2000. In the latter half of the period, premiums actually declined.⁵ In Massachusetts for instance, a state with one of the highest median medical negligence settlement payments and labeled a "crisis" state by the AMA, physicians actually paid less in inflation-adjusted premiums at the height of the crisis than they had 15 years earlier.⁶

Why then the call of a medical negligence crisis? The answer, at least in part, is that other expenses besides premiums increased while practice revenue declined.

Upon analyzing the issue, researchers at Suffolk University found medical negligence expenses were 11 percent of total practice expenses in 1986 as compared to 7 percent in 2000. Meanwhile, practice revenue also declined. From 1996 to 2000, physicians' average income dropped nearly 10 percent (\$254,229 in 1996 to \$229,500 in 2000). The researchers concluded, "It was revenue decline and increases in nonpremium expenses, not premium increases, that account for the overwhelming share of falling income."⁷ However, they went on to point out that even during this "crisis," average physician income was still in the 95th-99th percentile of all Americans.⁸

¹ Katherine Baicker and Amitabh Chandra, *supra* note 49.

² Michelle M. Mello, David M. Studdert, Jennifer Schumi, Troyen A. Brennan, William Sage, *Changes in Physician Supply and Scope of Practice During a Malpractice Crisis: Evidence from Pennsylvania*, *Health Affairs* 26, no.3, April 24, 2007.

³ 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*, Volume 5, Issue 1, 21-53, March 2008.

⁴ Derived from data provided by Medical Liability Monitor (Oct 2001 & Oct 2008). A state's average premium is calculated as the unweighted mean value of premiums for all companies for which data is provided across all regions. A state is classified as having a cap when the state has enacted either a general non-economic damage cap that affects medical malpractice cases or a medical malpractice specific cap on non-economic and/or compensatory damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not counted since these represent a small number of cases. Note: several states switched categories during this period and were thus excluded from the analysis. From a research design perspective it is imperative that variables maintain consistency over time. Premiums represent the average of internal medicine, general surgery and OB/Gyn rates.

⁵ Marc A. Rodwin, Hak J. Chang, Jeffrey Clausen, *Malpractice Premiums and Physicians' Income: Perceptions Of A Crisis Conflict With Empirical Evidence*, *Health Affairs*, Volume 25, no. 3, May/June 2006.

⁶ Marc A. Rodwin, Hak J. Chang, Melissa M. Ozaeta, Richard J. Omar, *Malpractice Premiums in Massachusetts, A High-Risk State: 1975 To 2005*, *Health Affairs*, Volume 27, no. 3, May/June 2008.

⁷ Marc A. Rodwin, Hak J. Chang, Jeffrey Clausen, *Malpractice Premiums and Physicians' Income: Perceptions Of A Crisis Conflict With Empirical Evidence*, *Health Affairs*, Volume 25, no. 3, May/June 2006.

⁸ Chart: *The Wealthiest Benefit More from Recent Tax Cuts*, *New York Times*, June 5, 2005.