Medical Negligence:

The Role of America's Civil Justice System in Protecting Patients' Rights

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Executive Summary

The Health Care Debate

The reform of the country's health care system remains a controversial debate for Congress and the administration. Much of this discussion focuses on the cost of health care and the driving factors behind it. In that context, some have demanded restrictions on patients' rights to hold negligent healthcare providers accountable, but have refused to pay attention to reducing and eliminating preventable medical errors. A large body of research now indicates that many of the common perceptions about medical negligence are little more than myths. This report analyzes the most recent empirical work on medical negligence to better understand the challenges facing the health care system.

Preventable Medical Errors – The Sixth Biggest Killer in America

According to the Institute of Medicine, preventable medical errors kill as many as 98,000 Americans everyyear, and injure countless more. If the Centers for Disease Control (CDC) were to include preventable medical errors as a category, it would be the sixth leading cause of death in America. Yet despite this, much of the medical negligence policy debate has revolved around indirect factors, such as doctors' insurance premiums. Any discussion of medical negligence that does not involve preventable medical errors ignores the fundamental problem. Preventing medical errors will dramatically lower health care costs, reduce doctors' insurance premiums, and protect the health and well-being of patients.

An Epidemic of Negligence, Not Lawsuits

Despite the shocking number of medical errors, few injured patients ever file a medical negligence lawsuit, and fewer still file frivolous claims. Research shows almost all medical negligence claims are meritorious. Claims where there was no error are rarely paid and researchers have concluded the reverse – errors which are never compensated – is a far bigger problem. The reality is, as University of Pennsylvania law professor Tom Baker puts it, "We have an epidemic of medical malpractice, not of malpractice lawsuits."

Patients Want Accountability

Far from looking for a jackpot, research shows that patients file claims because they are seeking accountability. Too often patients injured by preventable medical errors are left in the dark about what happened to them. The majority of patients who experience medical errors are not told by their doctor. Nearly one half of the nation's doctors admit to not reporting incompetence or medical errors. On the other hand, hospitals and health systems that have embraced full disclosure of medical errors to patients have found the number of medical negligence claims and their related costs decline.

Better Patient Safety is Key to Lower Health Care Costs

The rising cost of health care just intensifies the need to focus on preventable medical errors and their huge associated costs. The savings from preventing medical errors run into billions of dollars. The savings from restricting patients' access to justice, however, are negligible. Medical

negligence costs amount to less than two percent of health care spending, and government economists estimate restricting all patients' compensation would only lower health care costs by less than one-half of one percent or less. Preventative reforms that focus more on the medical industry rather than the legal system are a key part of any effort to making health care more affordable and accessible.

Medical Negligence "Reform" Just Fills Insurance Company Coffers

Limiting patients' rights does nothing but fill the coffers of malpractice insurance companies. A large body of research has shown that claims have remained stable for decades, while insurance companies have drastically raised physician premiums to build huge surpluses. States which have enacted caps on damages have seen hospitals and malpractice insurance companies make tens of millions of dollars but not cut the prices they charge patients and health insurers. Meanwhile, the cost of health care continues to rise at near-record levels.

Doctors Are Not Fleeing

The most frequently echoed myth concerning medical negligence is the notion that doctors are fleeing states and retiring early, creating physician shortages. Anecdotal accounts of doctors fleeing states in response to increased insurance premiums have proved to be either unrepresentative isolated events, or flat out false. In fact, data from the American Medical Association (AMA) show that physician numbers have been increasing across the board for many years. Not only are there record numbers of physicians in the U.S., the increase has also significantly outpaced population growth. There are now twice as many physicians per 100,000 population as there were when the AMA began tracking figures in the 1960s.

The number of physicians per 100,000 population is significantly higher in states without caps. This fact is supported by a large body of research that has found physician supply is not connected to insurance premiums. Researchers at the National Bureau of Economic Research (NBER) 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."

The Civil Justice System Makes Us Safer

Every profession has its bad apples and physicians are no exception. Just six percent of doctors are responsible for nearly 60 percent of all medical negligence, and the civil justice system is the only effective means for holding them accountable. Other disciplinary mechanisms are woefully inadequate. State medical boards, for instance, are supposed to discipline doctors who consistently violate standards of care. Yet two-thirds of doctors who make 10 or more medical negligence payments are never disciplined at all. Hospitals are on the front lines of patient safety, yet nearly half of all U.S. hospitals have never reported a disciplinary action to the National Practitioner Databank since its creation in 1990. Alternative compensation systems, such as health courts, propose eliminating or greatly sidelining disciplinary systems altogether.

The civil justice system holds doctors, hospitals and insurance companies accountable. It is this accountability that drives the development of patient safety systems that help prevent negligence before it occurs. Hospitals, health systems and even entire medical fields have reformed dangerous practices because of the civil justice system. Without the accountability the civil justice system enforces, patient safety will suffer and health care costs will go up for everyone.

The Problem

Preventable Medical Errors

Preventable medical errors kill and seriously injure hundreds of thousands of Americans every year. Any discussion of medical negligence that does not involve preventable medical errors ignores this fundamental problem. And while some would prefer to focus on doctors' insurance premiums, health care costs, or alternative compensation systems – anything other than the negligence itself – reducing medical errors is the best way to address all the related problems. Preventing medical errors will lower health care costs, reduce doctors' insurance premiums, and protect the health and well-being of patients.

The Institute of Medicine's (IOM) seminal study of preventable medical errors estimated as many as 98,000 people die every year at a cost of $29 billion.[1] If the Centers for Disease Control (CDC) were to include preventable medical errors as a category, these conclusions would make it the sixth leading cause of death in America.[2]

Leading Causes of Death in United States

	Cause	Deaths
1.	Heart Disease	652,091
2.	Cancer	559,312
3.	Stroke	143,579
4.	Chronic lower respiratory diseases	130,033
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

Further research has confirmed the extent of medical errors. The Congressional Budget Office (CBO) found that there were 181,000 severe injuries attributable to medical negligence in 2003.[3] The Institute for Healthcare Improvement estimates there are 15 million incidents of medical harm each year.[4] HealthGrades, the nation's leading healthcare rating organization, found that Medicare patients who experienced a patient-safety incident had a one-in-five chance of dying as a result.[5]

In the decade since the IOM first shined a light on the dismal state of patient safety in American hospitals, many proposals for improvement have been discussed and implemented. But recent research indicates that there is still much that needs to be done. Researchers at the Harvard School of Medicine have found that even today, about 18 percent of patients in hospitals are injured during the course of their care and that many of those injuries are life-threatening, or even fatal.[6] Recently the Joint Commission Center on Transforming Healthcare reported that as many as 40 wrong site, wrong side and wrong patient procedures happen every week in the U.S.[7]

Similarly, researchers in Colorado recently found that surgical "never" events, which are mistakes that should never happen, such as operating on the wrong patient or wrong site or performing the wrong procedure, are occurring at an alarming rate.[8]

Yet despite these numbers, the American public remains unaware of just how pervasive the problem is. Even though one in three Americans say that they or a family member has experienced a medical error, and one in five say that a medical error has caused either themselves or a family member serious health problems or death, surveys show that Americans vastly underestimate the extent of medical errors.[9] About half of respondents believe the annual death total from medical errors to be 5,000 or less—nearly 20 times lower than the IOM's estimate.

> *"We have an epidemic of medical malpractice, not of malpractice lawsuits."*
>
> **Tom Baker, Professor of Law**
> **University of Pennsylvania**

People have been led to believe that there are hundreds of thousands of 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 of patients dying 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."[10]

This false impression is in part fueled by the hospital industry, which does a disservice to patients by systematically covering up mistakes and problems. For instance, federal law requires hospitals to report incidences in which doctors have been disciplined to the National Practitioner Databank (NPDB), founded in 1990. However, in the two decades since its creation, nearly half of all U.S. hospitals have failed to report even a single incidence of doctor discipline. Hospitals perpetuate a harmful air of secrecy by using loopholes to avoid reporting problems, such as restricting the privileges of physicians guilty of negligence and misconduct for 29 days to avoid reporting requirements associated with restrictions of 30 days or more.[11]

Much of the discussion surrounding medical negligence revolves around costs, whether it be the cost of physicians' insurance or the cost to the health care system. While these are the subject of much debate, the potential savings from the elimination of medical errors are undeniable.

The Center for Medicare & Medicaid Services (CMS) has, in recent years, recognized the potential for financial savings by reducing medical errors. CMS has stopped paying for certain hospital and practitioner errors and thus created a financial incentive for hospitals to embrace patient safety. After evaluating a number of billable hospital-acquired conditions, CMS and the CDC decided on eight expensive but "reasonably preventable" secondary conditions that would not be reimbursed by Medicare, and could not be billed to patients.[12] Previously, Medicare rewarded hospital errors with larger reimbursements, by paying them an extra amount to treat various preventable complications that developed as a result of hospital negligence.

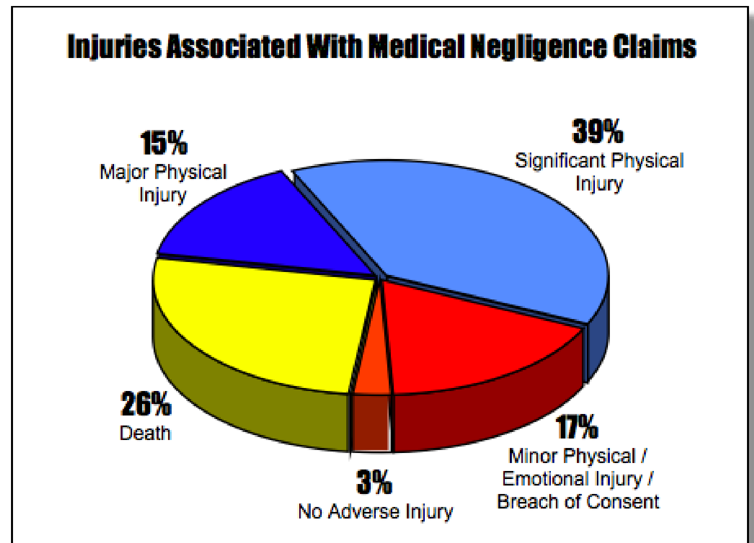
The new rules, which went into effect in 2008, are expected to save taxpayers at least $21 million annually and will encourage hospitals to take steps to avoid "reasonably preventable" hospital acquired conditions.[13] Private insurers like Blue Cross/Blue Shield Association and Aetna have also implemented similar policies not to reimburse medical providers for care related to problems or complications that should not occur in the normal course of hospitalization.[14]

Though CMS' policy of not paying for never events is a big step in the right direction for patient safety, it has yet to show real results in reducing harm. A November 2010 report released by the Office of the Inspector General at the U.S. Department of Health and Human Services (HHS) found that one in seven Medicare patients are injured during hospital stays and that adverse events during the course of care contributes to the deaths of 180,000 patients every year. These adverse events cost the government and taxpayers an additional $4.4 billion annually.[15]

The Patients

Medical Negligence Lawsuits Few and Far Between

Although much attention has been given to "medical negligence liability crises," in reality, very few injured patients ever file a medical negligence lawsuit.



In 2006, researchers at Harvard University announced the results of a study showing that most negligence claims involve medical error and serious injury, and concluded "portraits of a malpractice system that is stricken with frivolous litigation are overblown."[16] The researchers found that few claims were without merit, and those that were generally did not receive any money. Most negligence claims were meritorious, with 97 percent of claims involving medical injury and 80 percent involving physical injuries resulting in major disability or death. Few claims where there was not error were ever paid. In fact, researchers found the reverse – non-payment of claims where error was involved – was a bigger problem.

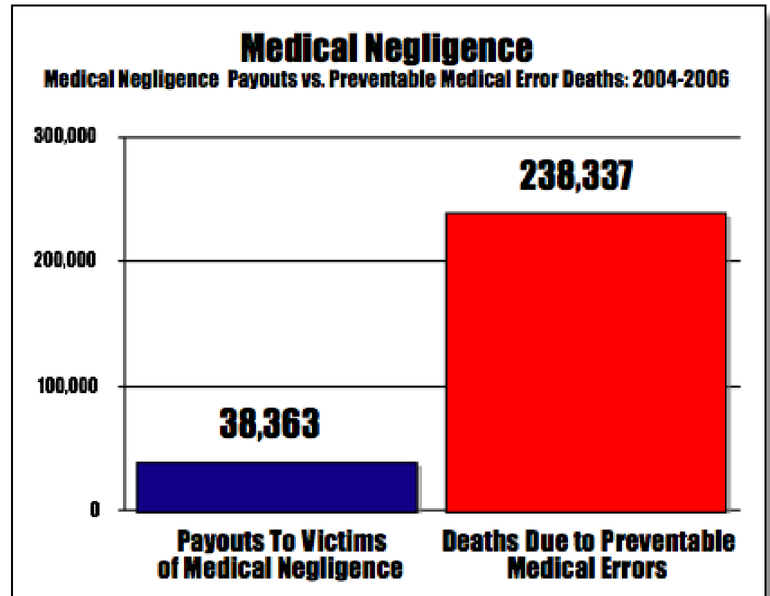
> *"[T]he major problem out there is medical errors that are not compensated, rather than frivolous claims that are compensated."*
>
> William Sage, Vice Provost for Health Affairs
> University of Texas at Austin

Co-author William Sage commented, "These findings are absolutely no surprise to any of us in the policy community. They are consistent with everything we suspected and learned from research over last 20 years, which is that the major problem out there is medical errors that are not compensated, rather than frivolous claims that are compensated."[17]

This conclusion also did not surprise the patient safety movement. Kaiser Family Foundation President Drew Altman said, "Maybe the question instead of 'Why do we have so many lawsuits?' is 'Why do we have so few?'"[18]

According to the National Center for State Courts (NCSC), only 4.4 percent of the civil caseload is comprised of tort cases. Of that subsection, just 2.8 percent comprise medical negligence cases. And even that tiny number has declined by 15 percent over the last 10 years.[19] Data from other sources such as the National Practitioner Databank, to which all physicians' medical malpractice payments must be reported, confirms the same downward trend.[20]

Even patients who are the victims of errors that should never happen are reluctant to sue. Researchers in Colorado found that of patients who were operated on in error or who received operations on the wrong site, only 21.5 percent filed a claim or a lawsuit.[21]



When the number of medical negligence payouts made every year is compared to the number of suspected deaths from preventable medical errors, it is easy to see why researchers have concluded that there are too few malpractice claims, not too many.[22]

The Search for Accountability

While the high cost of future medical care causes malpractice awards to be high, they are far from the million-dollar awards tort reformers claim. According to the National Practitioner Databank, the median medical malpractice award was $175,000 in 2006.[23] Data from the Department of Justice's Bureau of Justice Statistics (BJS) paints a similar picture. BJS researchers examined medical malpractice insurance claims in select states and found median awards ranging from $107,000 in Missouri to $195,000 in Texas.[24] Only between 5.5 percent (Florida) and 10.6 percent (Texas) of insurance payouts were for $1 million or more. A comprehensive analysis of insurance industry expenditures by Americans for Insurance Reform (AIR) similarly concluded, "inflation-adjusted payouts per doctor not only failed to increase during the last several years, a time when doctors' premiums skyrocketed, but they have been stable or falling throughout this entire decade. Payouts (in constant dollars) have essentially remained flat or dropped since the mid-1980s."[25]

Far from looking for a jackpot, research shows that patients actually file claims because they are seeking answers. Too often, patients injured by preventable medical errors are left in the dark about what happened to them, and litigation is sometimes the only way to uncover what transpired. A Kaiser Family Foundation survey found that 70 percent of patients who experience medical errors are not told by their doctors.[26] A national survey from Columbia University's Institute on Medicine as a Profession (IMAP) similarly found that nearly one half of the nation's doctors failed to report incompet colleagues or medical errors.[27]

The vast majority (92 percent) of the public believe that reporting serious medical errors should be mandatory and public.[28] However, state reporting programs are plagued by underreporting, despite research from the National Academy for State Health Policy (NASHP) demonstrating that there is no relationship between mandatory reporting and increases in malpractice claims.[29] The only national database of malpractice claims, the National Practitioners Databank (NPDB), is still closed to the public and has been deliberately undermined by the American Medical Association (AMA), which goes so far as to offer its members a primer on "How to evade a report to the NPDB."[30]

Hospitals too contribute to the air of secrecy. Though they are on the front line of patient safety and are required to review medical care through peer review and other processes, 49

percent of U.S. hospitals have never reported a single disciplinary action against one of their doctors since the National Practitioner Databank was created in 1990.[31]

On the other hand, hospitals that have embraced full disclosure of medical errors have found the number of malpractice claims and their related expense decline. The Veterans Affairs (VA) hospital in Lexington, Kentucky, has been a leader in the field by offering a strong disclosure program coupled with quick and fair offers of compensation when appropriate. Average settlements at the institution are now around $15,000 as opposed to $98,000 at other VA hospitals.[32] It is a recognition of the fact that patients are searching for accountability, not jackpots.

Patients Left in the Dark

Sharon Moore, a 58-year-old grandmother and widow in Washington state, died in 2006 after being treated with a massive combination of painkillers. Her physician, Dr. David Earl, was already under suspicion with hospital and pharmacy staff for overprescribing narcotics. In fact, as many as 36 people were familiar with issues surrounding Dr. Earl.

At least seven patients suffered similar dangerous doses, and a state medical expert eventually found at least three others were killed by the treatment, including an elderly married couple who died within months of each other of "acute intoxication." But Moore and her family had no way of knowing about the medical staff's concerns. None of the incidents were originally reported to the state, despite Washington's requirement that staff report errors.

A report by the Inspector General of the federal Health and Human Services (HHS) found that hospitals not only did a poor job reporting adverse events, they often could not even track them. The IG's analysis of two undisclosed counties found that 112 of 120 events where patients had been harmed went unreported. The hospitals even failed to report two of the three deaths caused by adverse events.[33]

The Physicians

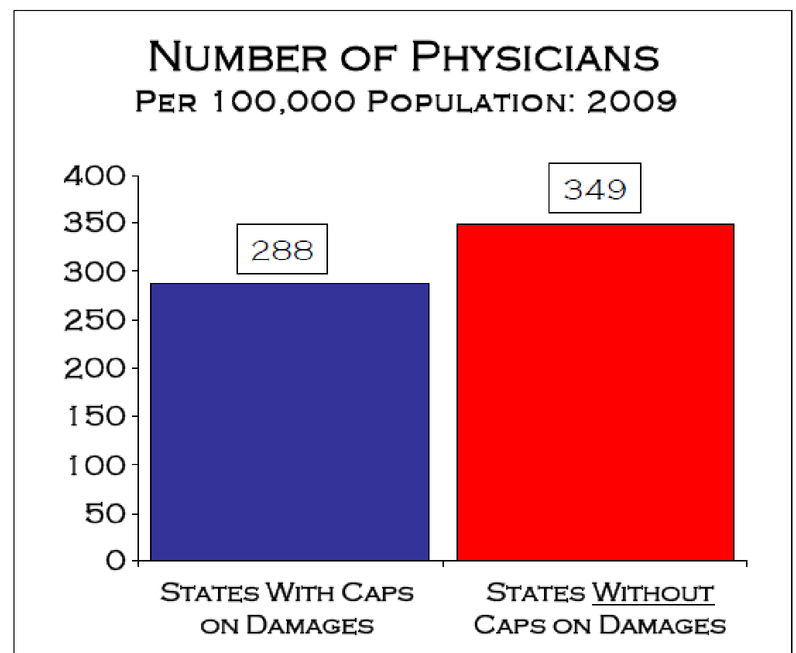
Doctors Are Not Fleeing the Profession

The most frequently echoed myth concerning medical negligence is the notion that doctors are fleeing states and retiring early, creating physician shortages. Anecdotal accounts of doctors fleeing states in response to increased insurance premiums have proved to be either unrepresentative isolated events, or flat out false. A Government Accountability Office (GAO) investigation found that "many of the reported provider actions taken in response to malpractice pressures were not substantiated or did not widely affect access to health care … some reports of physicians relocating to other states, retiring, or closing practices were not accurate or involved relatively few physicians."[34] In fact, data from the AMA shows that physician numbers have been increasing across the board for many years.

- The total number of physicians in the U.S. rose to a record high in 2009, the most recent year for which data are available. There were 972,376 physicians in the U.S., nearly 18,000 more than the year before.

- In 2009, 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 317. 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 AMA began tracking figures in the 1960s.

- The number of physicians per 100,000 population is 21 percent higher in states WITHOUT caps than in states with caps (349 v. 288).



Physicians and Premiums

Empirical research on the subject 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."[35] A study of Pennsylvania physicians by some of the leading medical malpractice researchers found that the number of physicians leaving their practices were similar both before and during the "malpractice crisis."[36] 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."[37]

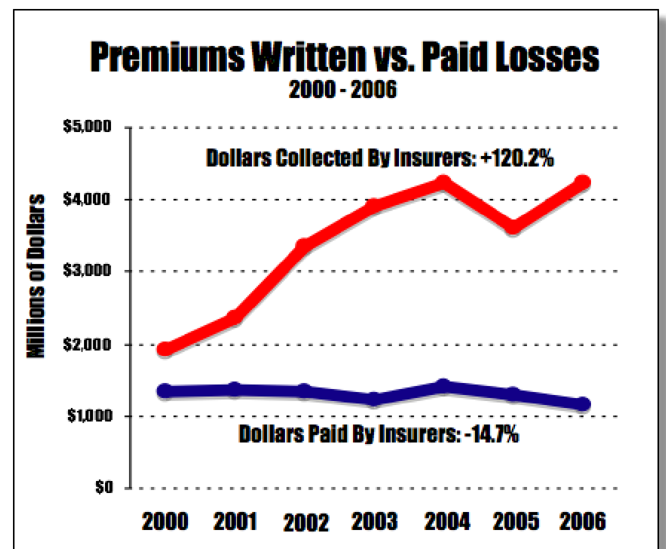
Data derived from *Medical Liability Monitor's* annual rate survey shows that the average premium in states with caps is actually higher than the average premium in states without caps. Tort reform has not achieved its intended goal of reducing physicians' malpractice premiums.

Stable Claims but Rising Premiums

Empirical research has found that there is little correlation between malpractice payouts and malpractice premiums. A 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."[38]

> *"[I]ncreases in malpractice payments made on behalf of physicians do not seem to be the driving force behind increases in premiums."*
> National Bureau of Economic Research

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." An analysis by Americans for Insurance Reform (AIR) likewise found no relationship between insurer payouts and premiums.[39] 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."[40] Instead, market dynamics, such as the fluctuation of investment income according to interest rate swings, were the sole cause of increased 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.[41] More recent research has found that insurers eventually paid out far lower levels of claims than they predicted during the so-called malpractice "crisis," and in fact continue to systematically overstate future losses as a way of disguising quite remarkable profits.[42]

For huge profits were indeed the result of several years of unjustified increases in premiums. In 2008, the average profit of the 10 largest medical malpractice insurers in the U.S. was higher than 99 percent of Fortune 500 companies and 35 times higher than the Fortune 500 average for the same time period. In fact, this may actually understate insurance industry profitability, given the industry's practice of systematically overestimating their losses and underestimating their profits. Revised statements of actual losses typically show that insurers reaped more profits than they initially reported.[43]

Research shows there may be politically-motivated reasons for medical malpractice insurance companies to overestimate their losses and underestimate their profits. In many cases, companies have used overblown reported losses as justification for legislation that restricts the rights of patients injured by medical negligence. Such tort reform measures have proven to be massively beneficial to insurance companies. In states with caps on damages, the average rate of profit is 24 percent better than in states without caps.[44] In states without caps, insurance companies took in just over twice what they paid out in 2008. However, in states with caps, insurance companies took in 3.5 times what they paid out. In effect, insurance companies continue taking in the same level of premiums, but pay out less in states with tort reform.[45]

The True Effect of Caps

Linda McDougal, 46, was diagnosed with an aggressive form of cancer in May 2002 and doctors recommended radical treatment, including the removal of both breasts. She awoke from a double mastectomy to hear her surgeon tell her, "You don't have cancer." While her first thoughts were of relief, very quickly, relief turned to horror.

Linda's surgeon said, "You never had cancer." Two pathologists had switched her biopsy results with another woman's – which meant both McDougal's breasts had been amputated unnecessarily. McDougal suffered ongoing infections and underwent emergency surgeries as a result of the unneeded mastectomies.

As tragic as cases such as McDougal's are, they rarely result in compensation in situations where a cap is in place. Without measurable economic losses such as lost wages victims can only claim pain and suffering awards. Given the cost of pursuing medical malpractice claims, this is rarely practical.[46]

A *Dallas Morning News* investigation of Texas' 2003 medical negligence cap found similar results. While hospitals and medical malpractice insurance companies made millions over the next few years, no hospital or doctor cut the prices they charged patients or health insurers. The cost of health care in Texas continued to rise at near-record levels.[47]

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.[48] 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.[49]

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."[50] 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.[51]

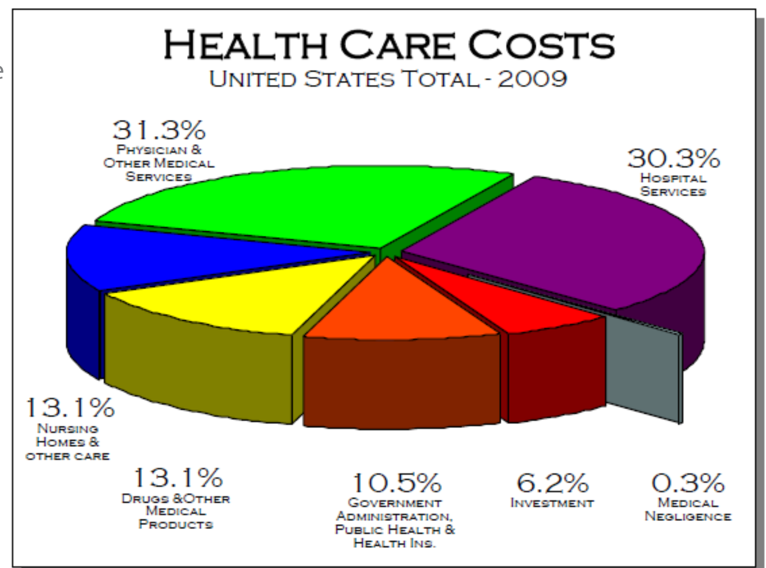
Costs

The primary reason for proposing changes to the medical liability system is the idea that it will reduce costs. However, research suggests that reforms will not lead to reductions in health care costs, but may actually make health care less safe for patients.

Malpractice a Tiny Percentage of Health Care Costs

One of the principal myths surrounding medical malpractice is its effect on overall health care costs. Medical malpractice is actually a tiny percentage of health care costs, in part because medical malpractice claims are far less frequent than many people believe.

In 2004, the CBO calculated malpractice costs amounted to "less than 2 percent of overall health care spending. Thus, 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."[52]



Five years later, the CBO revisited the issue of medical negligence costs. This time, they attempted to account for the indirect costs of medical negligence, mainly the idea that doctors order extra tests to avoid liability. Again, the CBO found that tort reform would only save 0.5 percent of all health care costs.[53]

Other authorities have also found that the direct costs associated with medical negligence are a tiny fraction of health care costs. According to the National Association of Insurance Commissioners (NAIC), the total amount of money spent defending claims and compensating victims of medical negligence in 2009 was $6.6 billion, or just 0.3 percent of the $2.5 trillion spent on health care in the U.S. that same year.[54]

Industry Profits

The tiny percentage of health care costs associated with malpractice claims is further put into context when compared to the profits of the hospital and insurance industries. The health insurance industry's profits rose by 56% in 2009. The top five for-profit health insurers made a whopping $12.2 billion. Meanwhile, 2.7 million Americans found their coverage dropped.[55]

Similarly, the medical malpractice insurance industry, while far smaller than the health insurance industry, has enjoyed remarkable profits in recent years. The top ten medical malpractice insurance companies alone made over $1 billion in profit in 2009. The average profit rate of the top 10 medical malpractice companies was eight times greater than the average for the Fortune 500. In fact, only five Fortune 500 companies could match the average profit level of the biggest medical malpractice insurers.[56]

Hospitals too have proven to be a profitable industry. More than a decade of mergers and consolidation has allowed many hospital chains to raise prices and has added an estimated $12 billion to annual health costs.[55]

Crushed By His Own Reform

Though tort reform theoretically benefits doctors most of all, the most vociferous proponents throughout the last 35 years have been representatives of big business and the insurance industry. One such proponent was Frank Cornelius.

As a lobbyist for the insurance industry in Indiana in the 1970s, Frank Cornelius helped to push a then pioneering $500,000 cap on medical malpractice awards and the elimination of pain and suffering compensation. He believed it would reduce health care costs and encourage physicians to stay in Indiana.

After a series of misfortunes, Cornelius saw the argument from the other side in the most personal way. After undergoing knee surgery in 1989, he developed a degenerative nervous disorder brought on by infection. His condition worsened when he was subsequently electrocuted by a physical therapist. A year later, another procedure went wrong when the surgeon used the wrong instrument and pierced the main vein from his legs to his heart, leaving him at risk of bleeding to death. When another physician attempted to save his life, he punctured his left lung.

Cornelius was left wheelchair-bound and on a morphine drip. On two occasions he received the last rites from his church. His marriage ended and at the age of 49, he was given two years to live.

In 1994, Cornelius wrote an impassioned letter to the editor that was published in the *New York Times*. In it he lamented his role in the passage of Indiana's medical malpractice cap and concluded,"the prospect that these 'reforms' will be enacted is frightening. Make no mistake, damage caps are arbitrary, wholly disregarding the nature of the injury and the pain experienced by the plaintiff… Medical negligence cannot be reduced simply by restricting consumers' legal rights. That will happen only when the medical industry begins to effectively police its own. I don't expect to live to see that day."
He died the following year.[57]

Defensive Medicine

Defensive medicine refers to the concept that doctors order unnecessary tests and medical procedures as a means to avoid medical negligence lawsuits. While proponents of tort reform argue that defensive medicine drives up the cost of health care, government researchers question to what extent defensive medicine really exists. The CBO has called the evidence of defensive medicine "not conclusive," and summarized, "on the basis of existing studies and its own research, CBO believes that savings from reducing defensive medicine would be very small."[58] Researchers at Dartmouth College echoed these conclusions, saying, "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."[59]

The GAO has issued similar statements questioning the occurrence of defensive medicine, saying, "the overall prevalence and costs of [defensive medicine] have not been reliably measured," and "study results cannot be generalized to estimate the extent and cost of defensive medicine practices across the health care system."[60]

Practicing "Defensively" Generates Extra Income for Doctors

To the extent that defensive medicine does exist, research has found that the motivation behind it is not liability but rather a desire to abide by a patient's wishes or, in some cases, boost physician income.

The GAO identified "revenue-enhancing motives" as one of the real reasons behind the utilization of extra diagnostic tests and procedures.[61] Similarly, in Florida, health authorities determined diagnostic-imaging centers and clinical labs were ordering additional tests because the majority were physician-owned and the tests provided a lucrative stream of income. Federal law now prohibits the referral of Medicare patients to certain physician-owned facilities, many of which charge double the amount in lab fees.[61] As researchers at the Harvard School of Public Health commented, "In medicine practiced as a business, defensive medicine is understood and may even be profitable."[62]

> *"[S]o-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by positive (albeit small) benefits to patients."*
>
> **Congressional Budget Office**

The CBO, in its analysis, recognized that there was a financial incentive but also identified health benefits to patients: "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."[63] Researchers at Tulane University found similar benefits to patients.[64] Their analysis of the National Practitioner Databank and the Nationwide Inpatient Sample (NIS) found that increased medical negligence risk was associated with an improvement in mortality, and concluded that to the extent defensive medicine existed it also had a positive effect on patients.

Defensive Medicine is Not Driving Up Health Care Costs

Despite the argument that tort reform would result in the elimination of defensive medicine and provide billions of dollars in savings, states that have already enacted tort reform show no sign of lowered health care costs. Texas, for instance, has some of the strictest caps in the country, yet has some of the highest health care costs in the country.
Many researchers believe that physicians cherry-pick patients and self-refer profitable procedures and insured patients to their own hospitals, pulling much-needed income from

community hospitals.[65] These self-referral "behaviors may damage the health care system at large by adding costs and weakening the health care safety net as community hospitals see their mix of patients becoming more complex and less well financed."[66] Even the hospital industry itself has recognized the problem. The American Hospital Association is currently debating a policy that would ban doctors from referring patients to hospitals in which they have a financial stake.[67]

Patients as ATMs

The highest rate of health care cost increase in the country has occurred in McAllen, Texas. Despite being in one of the poorest areas of the country, McAllen has some of the nation's highest health care costs per person. In fact, the $15,000 that Medicare spends per enrollee in McAllen is actually $3,000 more than the average McAllen resident earns.

Why are health costs so high? McAllen's own doctors are frank as to the cause – ordering extra tests to generate additional income. In the words of one McAllen doctor, "a lot of doctors here are practicing medicine in a way that treats the patients like ATM machines and essentially extracts the maximum amount of profit from the patient.

Doctors are able to profit not just from being physicians like we have traditionally but by ordering tests on equipment that they own, or sending patients to facilities that they own, or x-rays on equipment that they own, or sending patients to facilities that they own, or have a financial interest in."[68]

Theories of Defensive Medicine Rely on Debunked Research

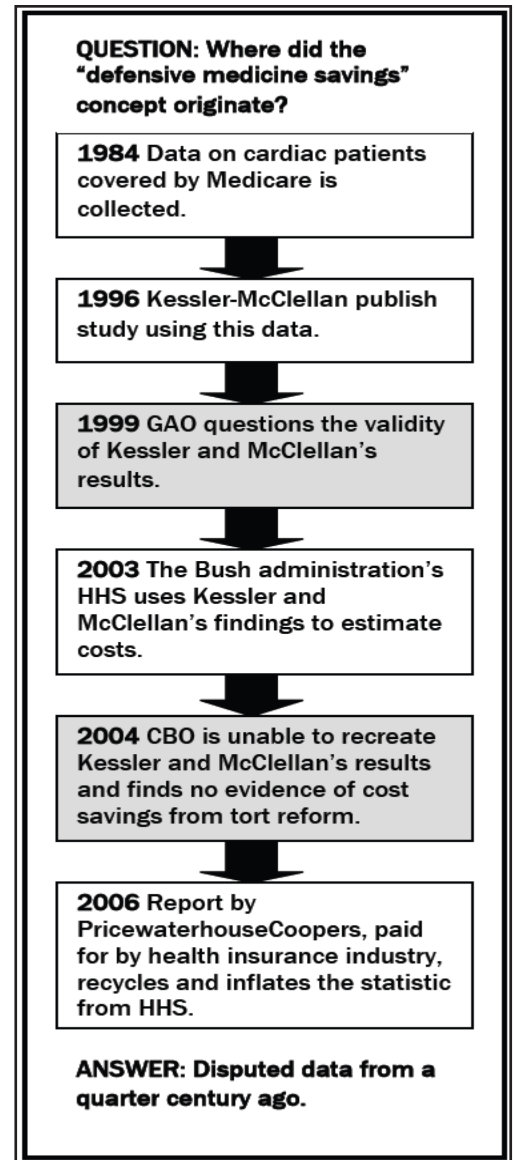
Theories surrounding the extent and cost of defensive medicine originate with one set of data a quarter century old. In 1996, two Stanford economists, Daniel Kessler and Mark McClellan, examined data on the costs of treating cardiac patients covered by Medicare in 1984, 1987, and 1990. The authors took this small subset of data and extrapolated the findings to the entire health care system to conclude that tort reform could reduce medical costs by five to nine percent because doctors no longer felt the need to run tests because of liability concerns.[69]

Subsequent academic and government analysis of the study was critical of its conclusions, and the vast bulk of empirical research since has consistently found no such savings. One government agency found that doctors who ordered tests almost always did so because of medical indications, and only one half of one percent of all cases involved doctors who ordered tests due to medical negligence concerns.[70] The GAO questioned the validity of the study's results in 1999, saying, "Because this study was focused on only one condition and on a hospital setting, it cannot be extrapolated to the larger practice of medicine. Given the limited evidence, reliable cost savings estimates cannot be developed."[71]

The CBO was unable to replicate the authors' findings and concluded there was "no evidence that restrictions on tort liability reduce medical spending… CBO found no statistically significant difference in per capita health care spending between states with and without limits on malpractice torts."[72]

Despite this, the Kessler/McClellan study continued to be spun by tort reform proponents. In 2003, the Bush administration announced that tort reform would save $60-108 billion by relying on the premise that not only was the Kessler/McClellan study accurate, but that every single incidence of defensive medicine would be eliminated.[73] Several years later, the most influential health insurance trade group, America's Health Insurance Plans (AHIP), commissioned PricewaterhouseCoopers to recycle the Bush administration figures. The accounting giant in fact decided to round up the Bush administration estimate, from 5-9% to 10%, without attempting to offer a justification.[74]

Thus, the basis behind the suggestions of huge savings achieved by the elimination of defensive medicine in fact originate with a 2006 report funded by the health insurance industry, which recycled a 2003 report from the Bush administration, which recycled a controversial 1996 study, which used data on a small subset of patients from 1984. This quarter century old data has formed the basis of tort reform claims ever since.



Physicians' Perceptions of Malpractice

While most physicians report being very concerned about the threat of malpractice lawsuits, there is empirical evidence that their perceptions are not in line with reality. Research suggests that "many popular tort reforms are only modestly associated with the level of physicians' malpractice concern and their practice of defensive medicine" and that physicians' perceptions of liability are "not an accurate assessment of actual risk."[75]

This overstatement of the threat of liability is a factor behind physicians' reluctance to report medical errors and negligence, even when committed by other doctors. In fact, 17 percent of physicians have reported having direct personal knowledge of an impaired or incompetent colleague, yet despite the risk to patient safety, only 67 percent of these doctors actually reported these individuals to their hospital or medical society.[76]

This aversion to the reporting of negligent and incompetent doctors even permeates the state medical boards that are supposed to be responsible for disciplining doctors. Texas, even after draconian medical negligence reforms, has a health care system that is no safer for patients than before the reforms, but no longer has a civil justice system to hold negligent doctors and hospitals accountable. Several *Dallas Morning News* investigations of the Texas Medical Board have revealed that doctors are reluctant to punish their colleagues, even as the number of complaints from patients has increased.

In the five years after the Texas cap was enacted, the number of complaints filed with the Texas Medical Board increased 35 percent. Yet only 15 percent of the complaints led to any sanctions and of the doctors who were disciplined, most only received a slap on the wrist. In one case,

a neurosurgeon who conducted four wrong site surgeries was ordered to attend 10 hours of continuing medical education classes. An emergency room physician who was unable to intubate a patient because he was drunk was ordered to attend therapy sessions and submit to urine tests. The consequences of his actions were much more severe for the patient: she died.[77]

The board is so reluctant to punish physicians that it has allowed a child psychiatrist who molested a young girl in his neighborhood to continue to practice for three years after the girl's mother filed a complaint. In the end, the therapist, by then a registered sex offender, was allowed to keep his license as long as he only treated adult men.[78]

Eric the Red

Dr. Eric Scheffey was a Texas orthopedic surgeon who earned the nickname "Eric the Red" during a two decade career that left hundreds of patients dead or maimed. Scheffey lost his privileges at three different hospitals and admitted abusing cocaine for 18 months.

Yet even after a judge recommended his license be taken away, the Texas Board of Medical Examiners allowed him to continue practicing. In 2005, after 24 years in practice and more than 78 medical negligence lawsuits, the board revoked his license.[79]

Reform Proposals

In recent years, many interest groups have proposed alternatives to the civil justice system. While none of these alternatives promise to deliver benefits that are not already achieved through the civil justice system, they do share one common theme: avoiding the accountability of the civil justice system.

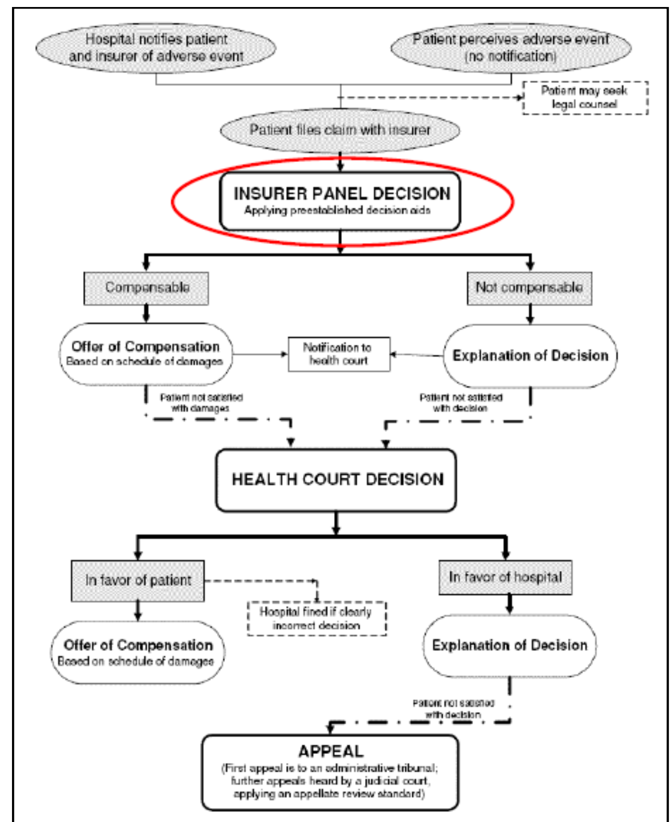
Health Courts—A Return to Managed Care

The concept of health courts is one such alternative compensation system being pushed by corporate defense lawyer Philip Howard and his group Common Good. Though health courts' advocates tout that the system would compensate many more patients than the civil justice system, the proposed system requires injured patients first have their claim evaluated by an insurance company before they are even allowed to enter a health court process (see flow chart). A system that relies on the good faith of insurance companies, particularly when doing anything but denying the claim is detrimental to their financial health, is doomed to result in the type of widespread fraudulent denials that haunted managed care.

In a health court system, each case would be decided by a health court judge, rather than a jury. The judge would be selected by politicians, opening the system to the machinations of special interests. All injuries would be treated according to pre-determined schedules regardless of the individual circumstances. A pianist who lost a finger would receive the same amount of compensation as a librarian, despite the vastly different professional and financial losses they would face.

Health courts would also be a hugely expensive and yet unfunded project. It would mandate the creation of an entirely new bureaucracy, and the subsequent administrative costs

associated with its operation. Health courts are modeled after the workers' compensation system, which gives some indication of the size of the costs involved. The administrative cost of the workers' compensation system amounts to $33 billion, or 38 percent of all money in the system. That administrative expense is significantly more than any estimate of the total cost of medical negligence, including payouts, expenses and administration. And there is every indication that a health court system would be substantially more expensive than the workers' compensation system because of the higher numbers of injured victims involved and the far higher incidence of serious injury. Because health courts would seek to compensate claims based on an "avoidability" standard of care, rather than the traditional "negligence" standard of care, there would be far more claims compensated than in the current system. Proponents of health courts admit that instituting such a system would cause physicians' malpractice premiums to rise.[80]



Perhaps the biggest drawback to a health court system is its potential effect on patient safety. It would do nothing to alleviate the stigma physicians associate with reporting medical errors.[81] The health courts model also requires eliminating or sidelining all physician discipline mechanisms in the hope of encouraging more candor. However, there is nothing to suggest that this will result in more candor, and everything to suggest it will merely give a free pass to the six percent of doctors who cause nearly 60 percent of all medical negligence.[82]

Apology Programs

Some advocates are now pushing a program that would encourage doctors and their insurers to openly disclose medical errors, offer apologies, and provide compensation to injured patients. Several hospitals nationwide are currently implementing medical error apology programs. Each hospital's program is different, but the standard concept of each program is the same. If a medical error occurs, the hospital voluntarily offers compensations, and the staff responsible for the error personally disclose the incident to the patient and apologizes. If the patient accepts the apology and the compensation offered, the patient is barred from filing further civil actions. The goal of such programs is to minimize errors, reduce hospital costs, and minimize the threat of litigation.

Groups advancing such apology program acknowledge that "anger – not greed – is what drives most customers to file medical malpractice lawsuits." Indeed, research has shown that most injured patients just want to know what went wrong in the course of their treatment and the only way they can do this is through the discovery process of litigation.

The concept originated with a program implemented by the Veterans Hospital Administration. In the 1980s, patient safety at VA hospitals was dismal enough to draw scathing rebukes

from both Congress and the GAO. VA hospitals had been "long notorious for serious lapses in medical safety."[83] In response, one VA hospital took a unique approach to error reporting by creating its own apology program. The Kentucky Veterans Administration Hospital in Lexington, Kentucky, began the program in 1987, and saw significant success in a relatively short period of time. By 2000, that hospital had settled 170 malpractice claims and gone to trial just three times. During this period, the hospital's average payout, across all claims, was $15,000: less than 20 percent of the VA system's average of $98,000.[84]

The University of Michigan Health System (UMHS) has also had success in implementing error disclosure and apology programs. After implementing a comprehensive program of error disclosure and compensation offers in February 2003, UMHS reported lower numbers of claims and shorter resolution times.[85]

Apology programs are now in place in certain hospitals around the country. But while they encourage accountability in physicians and hospitals, they also pose some dangers. Apology programs can serve to remove transparency from the system. Apologies themselves should not be admissible in court to prove fault, but in some instances, apology programs may be used to hold medical records or eye-witness accounts inadmissible. In addition, the stated goal of many apology programs is to reduce the number of claims and the cost of payouts, not necessarily to improve patient safety or better care for those injured. While the move toward accountability is to be applauded, patients injured by medical malpractice still deserve fair compensation for their injuries. The statute of limitations should be tolled to prevent programs from becoming nothing more than hospital delaying tactics. Nor should programs be allowed to become nothing more than mechanisms to obstruct patients from seeking representation. In some hospitals the apology programs are voluntary, or apply to some doctors but not others, creating confusion.

Medical Screening Panels

Recently, legislators have discussed proposals that would require injured patients to have their cases evaluated for merit by a medical screening panel before a lawsuit can be filed.

Screening panels are vulnerable to abuse in much the same way that disciplinary and error reporting requirements have been evaded by hospitals. Though most proposals aim to include medical experts, legal experts and community representatives, there is still the possibility that the balance of the panel could tip in one party's favor. Nor do the proposals clarify who is responsible for selecting panel members and what qualifications these members must have.

Screening panels can also harm patients by failing to delay the statute of limitations on medical negligence claims, potentially leaving an injured patient who has conscientiously complied with every step of the process without recourse. Nor are patients able to rely on discovery to gain access to vital medical records or witnesses.

There is little historical evidence that adopting screening panels would improve the medical liability system. At least seven states have repealed their panels and courts have overturned statutes in five others. Furthermore, research has found no evidence that screening panels reduce the size of payments or physicians' premiums.[86]

Joint and Several

Joint and several liability means that when more than one party is at fault for an injury and one defendant is unable to pay his or her portion of the damages, the other responsible party must pay the full amount of damages. The idea behind this common law rule is that the injured party should never bear the burden of paying for the injury.

In the context of medical malpractice, joint and several liability typically applies to doctors and hospitals. If in the event that both a doctor and hospital are both found to be at fault for a patient's injury and the doctor is unable to pay his or her full portion of damages to the injured patient, the hospital would pay the doctor's share.

Proponents of tort reform argue that the centuries-old doctrine is unfair because it makes defendants liable for more damages than they caused. This is just not the case. In fact, "[j]oint and several liability only applies to injuries for which the defendant herself is fully responsible. She is responsible for the entirety of some injury only if her tortuous behavior was an actual and proximate cause of the entire injury. She is not liable for injuries, including separable portions of injuries, to which she did not contribute. She is not liable unless the tortuous aspect of her conduct was an actual cause of the injury."[87]

Not only is reforming joint and several unfair to injured patients, it will actually increase costs for doctors. The CBO recently concluded that "[r]eform of joint-and-several liability rules… is likely to increase the financial liability of the providers assigned the greatest share of responsibility in malpractice cases – typically, physicians."[88]

Practice Guidelines

Physicians are expected to adhere to certain standards of treatment in their medical practices. These clinical practice guidelines of appropriate treatment are developed by health care experts and are typically understood to set the minimum standard of care.

In recent years, tort reformers have attempted to introduce these clinical practice guidelines as the legal standard of care in medical negligence cases. However, compliance with these guidelines should not provide physicians and hospitals with complete immunity from negligence claims. Research suggests that guidelines do not significantly alter physician behavior and that they struggle to adhere to them. As many as 16 percent of physicians simply refuse to follow them at all.[89] There are many barriers that keep physicians from following guidelines, particularly the inability to keep up with medical literature, a lack of familiarity with the guidelines that prevents physicians from knowing how to follow them, and a lack of agreement that the guideline is an appropriate treatment for the condition.[90] Guidelines concerning mammograms, for instance, were formally rejected by more than 40 leading medical centers within 48 hours of their introduction.[91]

Enterprise Liability

Under the current medical malpractice insurance system, doctors pay for their own liability insurance, and thus, are forced to absorb the cost when insurers raise premiums to offset

investment losses. One possible solution to the premium spikes associated with the insurance cycle would be for hospitals to pay for the malpractice insurance of their doctors.

The shifting structure of physician employment may make enterprise liability a logical solution to problems associated with the medical malpractice system. Traditionally, physicians have owned their own practices or worked for privately-owned clinics. But for new physicians coming out of medical school saddled with debt, the old employment structure may no longer be feasible. Many physicians are now taking salaried positions with hospitals.[92]

Researchers studying enterprise liability argue that liability insurance should be hospital-based because in their capacity to deliver patient care, "they are in the best position to make decisions about how to optimize the mix of potential risks and benefits associated with treatment of any particular patient's medical condition."[93]

Not only are hospitals in a better position than doctors to identify risks, they also have a greater capacity to identify trends in errors and improve the quality of care.

Why We Need the Civil Justice System

Injured Patients Overlooked

While the political debate over medical negligence tends to focus on doctors' insurance premiums or health care costs, one very important factor is often overlooked: the injured patients.

The injuries patients suffer from preventable medical errors are very real. Some are easily calculated, such as additional medical costs and lost wages, while others are less so, such as quality of life and pain and suffering. The problem with many medical negligence reforms is that they do not seek to prevent medical errors, but merely to shift the burden of these damages to the injured patients themselves.

Real Patients Inspire Real Change

Matthew Magargee was 28-years-old when he was diagnosed with non-Hodgkin's lymphoma, a disease that is generally treatable. As part of Matthew's outpatient chemotherapy treatment, he received two different drugs — one intravenously into his abdomen and one through a port into his head.

During a routine chemotherapy session, the oncologist and resident mistakenly switched the chemotherapy drugs. Matthew experienced severe pain as the drug mistakenly administered into his head destroyed everything it came into contact with.

Within minutes he had suffered extensive and irreversible brain damage. Matthew went into a coma and died two weeks later. While he was in the coma, his wife gave birth to their first child.

As a result of the lawsuit brought by Matthew's family, the hospital changed the way chemotherapy drugs are administered to patients. The two drugs that Matthew received simultaneously at each visit are now stored separately and administered to patients on different visits.[94]

Caps on non-economic damages are one such "reform" that do nothing to reform medical negligence at all. Non-economic damages compensate patients for very real injuries – such as the loss of a limb or sight, the loss of mobility, the loss of fertility, excruciating pain, or severe disfigurement, or even the loss of a child or a spouse. Many states have moved to cap these damages. The effect is often to render many medical negligence cases too expensive to bring to trial, especially for women, children, the elderly and the disabled – those who may not have suffered substantial economic loss, such as lost wages. University of Buffalo law professor Lucinda Finley found that such groups received damages far below average levels, and had a far harder time even getting to court because the expenses of a case often outweighed any potential award. She concluded, "caps benefit insurance companies by increasing their profits,

while producing no benefit for doctors, and causing a detriment to injured people, especially women and the elderly."[95] The 'reform' takes away the compensation, but does nothing to prevent the injuries.

Civil Justice and Patient Safety

Such reforms also take away a powerful deterrent to medical negligence. The civil justice system not only provides patients with their constitutional right to seek compensation for their injuries in a court of law; it also encourages patient safety systems that help prevent negligence before it occurs. Hospitals, such as Connecticut's Bridgeport Hospital, have reformed dangerous practices because of litigation. In some cases, entire medical fields have been transformed.

Bridgeport Hospital

In the late 1990s, hospital administrators at Bridgeport Hospital in Connecticut, were aware of a rash of infections caused by unsanitary conditions. Attempts to identify possible causes and solutions were ignored, partly for financial reasons. Eventually the staph outbreak resulted in a series of deaths.

Lawsuits filed resulting response uncovered a range of dangerous practices in the hospital, such as doctors not washing their hands before surgery and wearing non-sterile clothes in the operating room.

As a result, Bridgeport Hospital embarked on a $30 million renovation. The hospital upgraded its air filtration system and hand washing stations, and made changes to staff practices, such as a prohibition on doctors wearing scrubs home. These improvements drastically cut infection rates, from 22 percent of cardiac surgery patients to nearly zero.[96]

In the 1970s, anesthesiology was one of the highest risk medical specialties. In order to improve patient safety and reduce doctors' medical negligence costs, the American Society of Anesthesiologists created the Closed Claims Project to analyze data from lawsuits. Researchers were able to identify system failures and implement comprehensive practice changes. The results yielded a dramatic improvement in patient safety, and in the process, anesthesiologists drastically lowered their inflation-adjusted malpractice insurance premiums.[97]

Analysis of Anesthesiologists' Claims Data

Before the Closed Claim Project	After the Closed Claim Project
1 in 10,000 people who went under anesthesia died from the procedure.	1 in 200,000 people who went under anesthesia died from the procedure.
Anesthesiologists were responsible for 7.9 percent of all negligence claims.	Anesthesiologists were responsible for 3.8 percent of all negligence claims.
The average malpractice premium for anesthesiologists was $18,000 in 1985.	The average malpractice premium for anesthesiologists was $18,000 in 2002. Adjusted for inflation, the average anesthesiologist's malpractice premium dropped between 1985 and 2002.

More Tort Reform Equals Worse Health Care

Medical negligence lawsuits serve an important role in promoting public health and patient safety. Evidence suggests that the lessening of accountability that comes from reforms such as medical negligence caps can have a detrimental effect on patient safety and health care quality. A study from the American College of Emergency Physicians found that safety improves when injured patients can hold negligent hospitals or physicians accountable. States with aggressive legislation limiting patient access to the legal system are also the states that score lowest in patient safety. Overall, the 10 states doctors claim have the "best liability environment" (more tort reform) have a D+ score for patient safety (just two points above fail). In contrast, the 10 states doctors claim have the "worst liability environment" have a B- for patient safety, above the C+ national average. The 25 states with "best liability environments" all rank below the national average for patient safety.[98]

A study conducted by the National Bureau of Economic Research found that strict tort reforms adversely affect patient outcomes. The researchers found that a 10 percent increase in malpractice costs was associated with a 0.2 percent decrease in mortality rates. The authors concluded that, "while the mortality rates may be quite modest, these seem more likely than not to justify its direct and indirect heath care costs.[99]

Similarly, data collected from the non-partisan Commonwealth Fund show health care in states that cap damages in medical negligence cases tends to be of lower quality than health care in states that do not.[100] Patients in states that do not cap damages have better access to health care and are more likely to be covered by health insurance than patients living in states with caps on damages. The aforementioned study from Tulane University also found that states with more accountability experienced lower rates of mortality.[101] Analysis by Professors David Hyman and Charles Silver also found that insulating providers from liability was detrimental to patient safety, and concluded, "The widely held belief that fear of malpractice liability impedes efforts to improve the reliability of health care delivery systems is unfounded."[102] Professors Jonathan Klick and Thomas Stratmann similarly noted medical negligence reforms resulted in lower health care quality and increased infant mortality.[103]

Weeding Out Dangerous Doctors

Alternative compensation systems, such as health courts, propose eliminating or greatly sidelining procedures for disciplining doctors in the hope of fostering more candor over doctors' mistakes. However, every profession has its share of bad apples, and health care is no exception.

National Practitioner Databank (NPDB) data indicate just six percent of doctors are responsible for 58 percent of all negligence incidents.[104] The civil justice system seeks to weed out those few doctors whose actions have such devastating impact on patients.

The civil justice system is necessary because other disciplinary mechanisms are woefully inadequate. State medical boards, for instance, are supposed to discipline doctors who consistently violate standards of care. Yet less than nine percent of doctors who make multiple

malpractice payments are ever subject to medical board discipline. Two-thirds of doctors who make 10 or more malpractice payments are never disciplined at all.[105]

Nor are hospitals stepping up to protect their patients. Though they are on the front line of patient safety and are required to review medical care through peer review and other processes, 49 percent of U.S. hospitals have never reported a single disciplinary action against one of their doctors since the National Practitioner Databank was created in 1990.[106]

Screwdriver Surgeries

Dr. Robert Ricketson moved from state to state, leaving a raft of seriously injured patients in his wake before settling in Hawaii in 1998. He never told the Hawaii authorities about his disciplinary record or addiction to narcotics.

The next year during a spinal surgery, Ricketson found that the titanium rods he intended to implant in patient Arturo Iturralde's spine were missing. Rather than wait 45 minutes for the rods to be delivered, Ricketson cut up a stainless steel screwdriver and used the pieces to brace the spine. Days later, the screwdriver broke. Iturralde was rendered paraplegic and died two years later.[107]

Conclusion

Preventable medical errors kill and seriously injure hundreds of thousands of Americans every year. Only heart disease and cancer kill more Americans. Yet despite this, much of the medical negligence policy debate has revolved around indirect factors, such as doctors' insurance premiums. Any discussion of medical negligence that does not involve preventable medical errors ignores the fundamental problem. Preventing medical errors will dramatically lower health care costs, reduce doctors' insurance premiums, and protect the health and well-being of patients.

The accountability promoted by the civil justice system is the engine of patient safety. No other mechanism or proposed alternative encourages accountability as effectively as the civil justice system. Rather than seeking to undermine this accountability, we must bolster it. For in fostering accountability lies the key to both increased patient safety and lower health care costs. Without the civil justice system, patient safety will suffer and health care costs will go up for everyone.

Appendix - Patient Safety Initiatives

Investing in Patient Safety[108]

Problem	Cost of Problem	Solution	Effect of Solution
Medical Errors	98,000 Deaths $29 billion in costs	Computerized Medical Records Systems	Investment of $115 billion over 15 years can produce yearly savings of $81 billion from efficiency and error avoidance
Medication Errors	7,000 Deaths 1.5 million preventable Adverse Drug Events (ADEs) $3.5 billion in costs	Bar Coding Medicines and Equipment Computerized Physician Order Entry Systems (CPOE) Smart Pumps	$7 billion in savings per year Reduction of ADEs by 17% and serious medication errors by 55% Savings of $5 to $10 million (including implementation) per hospital per year 235 ADEs avoided per hospital each year Cost avoidance of $712,000 per hospital per year
Foreign objects retained during surgery	1,500 incidents of surgical tools left in patients each year $17.25 million in excess costs between 2000 and 2002	Radio Frequency Identification (RFID) Tags	Incidents of surgical tools left in patients are almost completely eliminated $8.8 billion investment over 4 years provides hospitals savings of up to $11 billion a year from enhanced inventory control
Hospital-Acquired Infections	2 million hospital patients acquire infections each year 90,000 people die annually from hospital-acquired infections Cost of $4.5 billion a year	Hand Washing Programs Minimize Ventilator-Associated Pneumonia Reduce Blood Infections from Central IV Lines	Estimated savings of $57,600 a year for a 300-bed hospital Allegheny General Hospital (Pittsburgh) invested $35,000 in a program that reduced infections by 83-87 percent and returned $4.3 million in savings
Post-Surgical Infections	500,000 incidences of post-operative infections per year Cost of $1.5 billion per year	Use of Prophylactic Antibiotics Use electric scissors instead of shaving Routine operating-room checklist[1]	Post-surgical infections drop to 1 in 200 patients 40-60 percent of surgical site infections can be prevented by using prophylactic antibiotics Using electric clippers can save $3 billion Checklist can save $15-25 billion in surgical complications costs

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