Medical Negligence Litigation is Not the Problem

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I. INTRODUCTION

Medical negligence is an epidemic in the United States. The Harvard Medical Practice Study examined hospitals in New York State and found that 2.1% of all hospitalized patients were injured due to medical error, causing disability or extended hospital stays.[1] A 2004 study of hospitals in Colorado and Utah confirmed the magnitude of this problem.[2] Medical negligence lawsuits result from injures due to acts of medical negligence. The high costs of medical negligence liability insurance reflect this high level of medical negligence. The most effective way to reduce the costs of medical liability insurance is to reduce the incidence of medical negligence.

Misleading and inaccurate myths about the source of the high costs of medical liability insurance distract attention from the causes of and solutions to the problems relating to the high cost of medical liability insurance. These myths serve to confuse the real issues. The myths include claims that large numbers of "frivolous" medical negligence cases are filed, that jury awards in medical negligence cases are "skyrocketing," that patients' access to healthcare is being restricted due to rising insurance costs, and that physicians practice so-called "defensive medicine" out of fear of liability. These frequently-repeated myths have been accepted by many political leaders, who by repeating these myths perpetuate them. President George W. Bush stated:

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1. Christina O. Jackiw, Comment, *The Current Medical Liability Insurance Crisis: An Overview of the Problem, Its Catalysts and Solutions*, 13 ANNALS HEALTH L. 505, 511 (Summer 2004) [hereinafter Health Law Colloquium].

2. *Id.*

> What's happening all across this country is that lawyers are filing baseless suits against hospitals and doctors. That's just a plain fact. And they're doing it for a simple reason. They know the medical liability system is tilted in their favor. Jury awards in medical liability cases have skyrocketed in recent years. That means every claim filed by a personal injury lawyer brings the chance of a huge payoff or a profitable settlement out of court. That's what that means. Doctors and hospitals realize this. They know it's expensive to fight a lawsuit, even if it doesn't have any merit. And because the system is so unpredictable, there is a constant risk of being hit by a massive jury award. So doctors end up paying tens of thousands, or even hundreds of thousands of dollars to settle claims out of court, even when they know they have done nothing wrong.[3]

Proponents and opponents of medical negligence tort reform agree that medical negligence liability insurance rates have greatly increased during recent years.[4] The medical negligence liability myth is not that there has been an increase in insurance premiums; the myth is the misplacing of the blame, the exaggeration of the results, and what the proposed solutions would accomplish. Economically-powerful organizations, including medical societies, health insurance plans, and medical liability insurers, exert great influence in the federal and state legislative arenas and have spent large sums of money promoting self-serving statutory changes based on these myths.[5] This article will explore the elements of the medical negligence myths to illuminate the causes of medical negligence liability and medical liability premium increases, examine the current litigation system, and offer suggestions as to how to address the main problem, that of an epidemic of patient injury and medical liability insurance premium increases.

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3. President George W. Bush, Speech at the Gateway Center in Collinsville, IL, *available at* http://www.whitehouse.gov/news/releases/2005/01/20050105-4 (Jan. 5, 2005) [hereinafter Bush Speech].

4. ISMIE, Illinois's largest provider of physician negligence insurance, raised its rates 35% in July, 2003 and another 7% in July, 2004. Keith A. Hebeisen, *Caps on Damages Reward Insurers at the Expense of Those Injured or Killed by Medical Malpractice*, 8 TRIAL J. 1 (Winter 2006).

5. Nathan Hershey and Christine M. Jarzab, *Looking at Accountability 40 Years After Darling*, 14 ANNALS HEALTH L. 437, 443 (Summer 2005).

II. THE MAJOR MYTHS

A. MYTH #1: PLAINTIFFS FILE FRIVOLOUS MEDICAL NEGLIGENCE LAWSUITS

Proponents of tort reform in medical negligence claim that many baseless claims are being filed against doctors and hospitals.[6] The statistics, simple business sense, and legal procedure do not bear this out for three reasons: 1) most medical negligence never results in a lawsuit; 2) medical negligence cases are expensive to prosecute; and 3) medical negligence lawsuits require certification by a physician in order to be filed in Illinois.

Several studies have demonstrated that the overwhelming majority of medical negligence injuries do not result in a lawsuit.[7] Most victims of medical negligence are never compensated for their injuries.[8] According to the Harvard Medical Practice Study, which examined hospitals in New York State, 2.1% of all hospitalized patients were injured due to medical error, causing disability or extended hospital stays.[9] A later study investigating hospitals in Colorado and Utah echoed the earlier study's findings.[10] Of those injured as a result of medical negligence, the Harvard study showed that fewer than 2% sued for medical negligence.[11] That means that for every injured patient who files a claim, 49 injured patients do not. Even those patients with the most severe or costly injuries caused by physician negligence were only compensated one-third of the time, according to the Harvard study.[12] Several other studies have confirmed this analysis: most medical negligence is not recognized, not litigated, and not compensated.[13]

The exorbitant expense of prosecuting medical negligence claims is one reason that many patients injured by medical negligence never receive compensation in Illinois and other similar states: they cannot find an

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6. *See, e.g.*, Statement, Cyril M. Hetsko, AMA: Wisconsin Supreme Court opens the door for a medical liability crisis, American Medical Association, *available at* http://www.ama-assn.org/ama/pub/category/15319.html (July 14, 2005) (discussing the Wisconsin Supreme Court's declaration that caps on non-economic damages are unconstitutional, and stating that caps are "proven to reduce frivolous lawsuits and stabilize insurance premiums."); *see also* Bush Speech, *supra* note 3.

7. *See, e.g.*, Hershey & Jarzab, *supra* note 5, at 442 (citing to The Institute of Medicine, *To Err is Human: Building a Safer Healthcare System* (2000)).

8. Joint Econ. Comm., 108th Cong., Liability for Medical Malpractice: Issues and Evidence 15 (Comm. Study 2003).

9. Health Law Colloquium, *supra* note 1, at 511.

10. *Id.*

11. Richard G. Roberts, *Understanding the Physician Liability Insurance Crisis*, FAM. PRAC. MGMT., (Oct. 2002), *at* http://www.aafp.org/fpm/20021000/47unde.html.

12. Mark Geistfeld, *Malpractice Insurance and the (Il)legitimate Interests of the Medical Profession in Tort Reform*, 54 DEPAUL L. REV. 439, 443 (Winter 2005).

13. *Id.*

attorney willing to take their case.[14] Medical negligence lawsuits are expensive, time-consuming to prosecute, and difficult to win. In order to file a medical negligence lawsuit in Illinois, a medical negligence plaintiff must pay filing fees and must retain an independent physician licensed in the same specialty as the defendant physician who certifies in writing that he or she has reviewed the pertinent medical records and that there exists a meritorious claim as to each defendant.[15] This independent expert must document the basis for this statement and must disclose his or her name, address, and license number with the certifying letter.[16] The plaintiff must pay substantial fees for the independent physician's time to review the medical records and write the report in order for the injured patient to even access the courts.[17] The present statute mandates that this report must be written separately for each defendant with a different specialty, which makes the certification letters more cumbersome and expensive and makes filing medical negligence lawsuits even more expensive.[18] To pursue a claim through trial costs an average of $35,000 to $50,000.[19] Only half of the plaintiffs who file lawsuits actually receive any compensation.[20] Of cases that go to trial, plaintiffs win a verdict only 29% of the time.[21] Because the costs and the difficulty in winning compensation for the injured patient are so high, and because of the statutory restriction on fees in Illinois for medical negligence cases,[22] plaintiffs' attorneys carefully screen their potential clients, accepting only those cases with strong liability and high damages.[23] Because of the high cost and because they are always

14. Monique A. Anawis, *Presentation: Tort Reform 2003*, 6 DEPAUL J. HEALTH CARE L. 309, 314 (2003) ("[W]hat happens to them is what happens in California. They can't get lawyers. Cases fall through the cracks . . . and that's exactly what the reformers want.").

15. 735 ILL. COMP. STAT. 5/2-622 (2005).

16. *Id.*

17. *See* Miller v. Gupta, 672 N.E.2d 1229, 1232 (1996) ("[T]he legislature has made the certificate of merit a condition of proceeding with a meritorious malpractice action."). *See also* Sherrod v. Ramaswamy, 732 N.E.2d 87 (5th Dist. 2000) (holding that a dismissal on the basis that the plaintiff did not file the appropriate physician report pursuant to 735 ILL. COMP. STAT 5/2-622 was a "dismissal on the merits").

18. 2005 Ill. Laws P.A 94-677 (modifying 735 ILL. COMP. STAT 5/2-622).

19. William P. Gunnar, M.D., *Is There an Acceptable Answer to Rising Medical Malpractice Premiums?*, 13 ANNALS HEALTH L. 465, 479 (Summer 2004).

20. Health Law Colloquium, *supra* note 1, at 510.

21. Roberts, *supra* note 11. That plaintiffs do not achieve a verdict for their clients so often does not result from frivolous lawsuits, but rather is due to the burden of proof and the complexities inherent in a medical malpractice case. *See* Herbert M. Kritzer, *Contingency Fee Lawyers as Gatekeepers in the Civil Justice System*, 81 JUDICATURE 22, 24 (1997) (noting that because contingent fee lawyers only succeed if the cases they accept succeed, attorneys screen out frivolous lawsuits).

22. 735 ILL. COMP. STAT. 5/2-1114 (2005).

23. Gunnar, *supra* note 19.

faced with a fierce defense,[24] plaintiffs' attorneys err on the side of rejecting, rather than accepting, difficult cases.[25] The economic reality of the business of the practice of law mandates that plaintiffs' attorneys cannot afford to file medical negligence lawsuits unless there is a high likelihood of liability and a severe injury involved. Empirical research supports this claim, as only one-third of even those most severely injured ever receive compensation for their injuries.[26] Not only are there few frivolous claims being filed, but most of the meritorious claims are not filed either.

Another factor mitigating against the claim that plaintiffs and their attorneys are filing baseless claims for medical negligence is the Rules of Professional Conduct applicable to attorneys. These Rules explicitly state that attorneys shall not bring a claim unless there is a basis for doing so that is not frivolous,[27] and shall not advance a claim the lawyer knows is unwarranted under existing law.[28] The Illinois Supreme Court Rules require that an attorney sign any pleading filed with the court, thereby certifying that, to the best of his or her knowledge after reasonable inquiry, the pleading is well grounded in fact and warranted by existing law.[29] If a pleading is signed in violation of this rule, the court, either by motion or its own initiative, may sanction the attorney or the party, which can include having to pay all costs incurred to defend the case to the inclusion of a reasonable attorney's fee.[30] If there had been an explosion of frivolous lawsuits, as claimed by tort reform proponents,[31] the attorneys bringing these cases would be sanctioned by the court. Further legislative action to prevent frivolous medical negligence lawsuits is unnecessary to combat a rare problem that already has solutions in place. Defendants, their insurers, and their attorneys have the tool available of filing a motion pursuant to Illinois Supreme Court Rule 137 to recover their costs for defending the "frivolous" lawsuits that tort reform proponents claim exist.[32] In twenty-

24. Health Law Colloquium, *supra* note 1, at 511.
25. Gunnar, *supra* note 19.
26. *See* Anawis, *supra* note 14, at 311.
27. ILL. R. OF PROF'L CONDUCT, R. 3.1 (2005).
28. ILL. R. OF PROF'L CONDUCT, R. 1.2(f) (2005).
29. ILL. SUP. CT. R., R. 137 (2005).
30. *Id.*
31. *See, e.g.,* Bush Speech, *supra*, note 3. *See also* Press Release, *Out of Control Insurance Premiums Driving Florida's Healthcare to Crisis Point*, Florida Medical Association, available at http://www.flains.org/newfic/mediapublic/latebreakingnews/fmaonmedmal53002.pdf (May 30, 2002).
32. *See, e.g.,* Press Release, *Paul Votes to Curb Frivolous Lawsuits*, Rep. Ron Paul, available at http://www.house.gov/paul/press/press2004/pr091604.htm ("Too many attorneys file too many frivolous lawsuits . . . [m]edical malpractice lawsuits especially have gotten out of control.") (Sept. 16, 2004).

two years of legal practice and thirty-eight years of medical practice, this author has never seen such a motion filed or granted.

B. MYTH #2: SKYROCKETING JURY AWARDS ARE CAUSING PREMIUMS TO RISE

The size of awards in medical negligence cases is primarily driven by the medical care costs of the injured patient.[33] Litigation behavior and medical negligence claim payments did not change in any significant, systemic sense between 1970 and 1975, between 1981 and 1986, or between 1996 and 2001 (previous medical negligence "crises").[34] Medical negligence tort costs have risen at an annual rate of 11.9%, only slightly higher than the rate of 9.5% for other types of tort cases.[35] Medical negligence judgments have increased at the same rate as medical inflation.[36] The difference between medical negligence and other tort cases is attributable to the increased costs for medical care, since a large portion of a plaintiff's award will be to cover past and future medical care that resulted from the negligence of the defendants.[37] Any claims that "skyrocketing awards" are due to something other than the high cost of healthcare are unsupported and deceptive.[38]

The medical negligence tort system tends to *under*compensate rather than overcompensate medical negligence victims.[39] Empirical studies have shown that the most severely-injured plaintiffs receive only 10-20% compensation on marginal losses.[40] The total amount of medical negligence liability is significantly less that the total cost to the economy that results from the injuries caused by medical negligence.[41] Physicians and

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33. Roberts, *supra* note 11.

34. Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393, 394 (Winter 2005) (citing David J. Nye & Donald G. Gifford, *The Myth of the Liability Insurance Claims Explosion: An Empirical Rebuttal*, 41 VAND. L. REV. 909 (1988)); Neil Vidmar et al., *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL L. REV. 315 (Winter 2005).

35. Symposium, *A Physician's Perspective on the Medical Malpractice Crisis*, 13 ANNALS HEALTH L. 623, 628 (Summer 2004).

36. Health Law Colloquium, *supra* note 1, at 514 (citing Americans for Insurance Reform (AIR), *Medical Malpractice Insurance: Stable Losses/Unstable Rates* 4 (2002)).

37. Baker, *supra* note 34, at 443.

38. Lewis Laska & Katherine Forrest, *Faulty Data and False Conclusions: The Myth of Skyrocketing Medical Malpractice Verdicts*, COMMONWEAL INSTITUTE (Oct. 2004).

39. Geistfeld, *supra* note 12, at 443.

40. *Id.* This means that for each 1% increase in injury, the claimant would receive only 0.1-0.2% in additional compensation.

41. *Id.* at 443-44.

other healthcare providers are held accountable for only a modest fraction of the harm they cause.[42]

The total amount of insurance premiums collected in 2003 was $215 billion.[43] The share attributable to medical negligence premiums was only $11 billion. This number is insignificant when compared to the more than $1.5 trillion spent on healthcare that same year. Costs constituting less than 1% of healthcare costs could hardly have the impact that proponents of the medical malpractice myth claim.[44] Even if the costs for medical negligence liability insurance were cut in half, a goal no one expects tort reform to accomplish, it would only have the potential to reduce healthcare costs by less than one-half of one percent.[45]

Insurance companies are paying out *less* in claims each year, despite charging more in premiums. According to the National Practitioners' Databank, the number of medical negligence payouts have *decreased* 36% between 1993 and 2002;[46] the amount paid out per claim has risen, but by less than 6% per year, more than 1% *less* than the rate of medical inflation.[47] ISMIE[48] paid out less in actual dollars in 2001 and 2002 than it did in 1993.[49] This reduction in payouts has contributed to record surpluses for the insurance companies over the past few years, despite their claims of a litigation "crisis" causing higher premiums.[50]

C. MYTH #3: ACCESS TO HEALTHCARE IS RESTRICTED; DOCTORS ARE LEAVING THE PROFESSION

Proponents of medical negligence tort reform regularly claim that insurance premiums are driving doctors out of the practice of medicine,

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42. Hershey & Jarzab, *supra* note 5, at 442.

43. Tom Baker, THE MEDICAL MALPRACTICE MYTH 9 (2005).

44. *Id.*

45. *Id.*

46. 503 reported payouts in 2002, 491 in 2003. National Practitioners' Databank.

47. Americans for Insurance Reform (AIR), *Medical Malpractice Insurance: Stable Losses/Unstable Rates* 4 (2002), *available at* http://www.insurance-reform.org/StableLossesIL.pdf (last visited Feb. 3, 2006).

48. Illinois State Medical Inter-Insurance Exchange, the state's largest physician negligence liability insurance provider.

49. Hebeisen, *supra* note 4.

50. Jay Angoff, *Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry*, (July 2005), Commissioned by the Center for Justice & Democracy. This study analyzed the activities of Illinois insurance companies from 2000-2004 and found that the amount of premiums collected had more than doubled during that time. Some companies even increased their premiums while both current and future payouts were declining.

causing patients to be abandoned and vulnerable,[51] a claim that is not new.[52] The facts refute these claims. The number of practicing physicians per capita in the United States[53] and in Illinois[54] has been increasing, not decreasing. There have always been episodic, focal shortages of doctors in rural areas, in inner-city neighborhoods, and in the some of the fastest-growing areas of the country, such as Nevada.[55] These shortages, which have been a problem for many decades, are due to traditional demographic factors, including social factors such as lifestyle choices of specialists and their spouses, limited opportunities for professional work for well-educated spouses of physicians, limited recreational and shopping opportunities, danger of crime in some inner-city areas, and limited specialized educational opportunities for their children.[56] These regions face difficulties in recruiting other professionals as well, such as teachers, for the same reasons. These traditional causes for focal physician shortages, which have existed in rural areas for decades, could be exacerbated by increased insurance premiums.[57] This exacerbation is due not to increased litigation in those areas, but rather is due to unfair pricing schematics utilized by insurers.[58]

Obstetrics is often cited as a specialty area from which many physicians have fled, abandoning the practice entirely.[59] The anecdotal evidence related by tort reform proponents relies heavily on those doctors who did not deliver very many babies on a yearly basis.[60] The insurance companies charge the same premiums to physicians who episodically deliver babies, such as family practitioners, as they do to obstetricians who deliver hundreds of babies annually. Instead of continuing to episodically deliver babies, physician groups have decided instead to funnel this function to

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51. Susan Shaw, *Medical Errors and Diabetes Care*, Diabetes Health Mag., Mar. 2003, *available at* http://www.diabeteshealth.com/print,article,2950.html ("Outrageous liability rates are driving physicians from their practices, leaving patients vulnerable and the entire field of medicine in a state of turmoil.").

52. Baker, *supra* note 43, at 140 (quoting Frank Hamilton, who claimed that between 1833 and 1856, suits for malpractice were so frequent that many men abandoned the practice of surgery).

53. *Id.* at 141.

54. Bob Tita, *More Docs in Illinois*, CRAIN'S CHI. BUSI., July 5, 2004 at 3.

55. Baker, *supra* note 43, at 144.

56. U.S. Gen. Acct. Off., *Medicare Physician Fees: Geographic Adjustment Indices Are Valid in Design, but Data and Methods Need Refinement*, GAO-05-119 (Mar. 11, 2005), *available at* http://www.gao.gov/atext/d05119.txt.

57. Baker, *supra* note 43, at 144-45.

58. *Id.* at 145.

59. Bush Speech, *supra*, note 3 (stating there are "pregnant moms all over America who are wondering whether or not they're going to be able to find good quality health care for their child and themselves").

60. Baker, *supra* note 43, at 146.

specialized physicians because the amount paid for liability insurance does not vary based on the number of deliveries performed.[61] Overall, the likely impact of this specialization has been at worst neutral and possibly positive for the healthcare outcomes of patients.[62] More research is needed on the impact of this specialization on the availability of obstetricians in rural areas, a problem that has existed for decades, as the bare assertions made by tort reform proponents are not based on any serious research.[63]

There are more physicians, per capita, in the United States than there has ever been before.[64] The number of physicians practicing in Illinois has also increased, outpacing population growth. *Crain's Chicago Business* reported that as of May 2004, the number of licensed physicians in Illinois was up 5.3% from the previous year.[65] There has been a steady increase in the number of doctors licensed to practice in Illinois, even in the high-risk specialty fields from which physicians were supposedly fleeing.[66] The U.S. General Accounting Office has stated in a report that doctors' groups have misled and fabricated evidence, or, at the very least, wildly overstated their case about how medical negligence problems have limited access to healthcare.[67] The GAO has also stated that while some physicians have moved away from "malpractice crisis" states, the number of physicians per capita has remained relatively unchanged, indicating consistent accessibility to healthcare.[68] The GAO report stated that the reported cases of doctors leaving are inaccurate or involve relatively few physicians.[69] The anecdotal "evidence" cited by tort restriction proponents is mainly the result of normal worker mobility, similar to any other profession. The only legitimate question remaining is whether distribution of physicians is impacted negatively (for rural patients' access) due to unfair pricing of medical negligence liability insurance.[70]

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61. *Id.*
62. *Id.* at 147.
63. *Id.*
64. *Id.* at 141.
65. Tita, *supra* note 54, at 1.
66. Christi Parsons & Bruce Japson, *Physician Count Clouds Malpractice Argument*, CHI. TRIB., July 16, 2004, § 3, at 1.
67. *Id.*
68. U.S. Gen. Acct. Off. rep. to Cong. Requesters, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836, 35 (2003).
69. *Id.*
70. Baker, *supra* note 43, at 147.

D. MYTH #4: DOCTORS, TERRIFIED OF NEGLIGENCE LIABILITY, ROUTINELY ENGAGE IN "DEFENSIVE MEDICINE"

Proponents of tort reform claim that the high incidence of medical negligence lawsuits has caused physicians to practice "defensive medicine," whereby physicians order additional unnecessary tests and/or procedures to avoid medical negligence liability, a claim impossible to verify or quantify, but likely untrue. If a test or procedure were medically unnecessary and were ordered by a physician, health insurance companies would likely refuse to pay for it, angering patients who would then have to pay for these tests or procedures.[71] This has apparently not occurred. The risks of a medically-unnecessary test or procedure would likely create physician liability instead of helping him or her avoid liability, and would be counterproductive.[72] The best defense a physician can have against claims of medical negligence is to not commit negligent acts. A physician who documents in the patients' chart a reasonable plan for care, including diagnosis and treatment, provides his or her own defense.[73] It is irrational and counterproductive (and if it causes injury, negligent) for physicians to order unnecessary and risky tests or procedures that are not medically necessary.

It is difficult, if not impossible, to measure the cost of defensive medicine even if it does exist.[74] If medical negligence lawsuits have an effect on the practice of medicine, they encourage physicians to order additional tests and/or procedures beneficial to the patient as well as those that may not

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71. *See* Baker, *supra* note 43, at 134 ("[T]he increased cost-consciousness of the managed care movement has pushed back, hard, in the opposite direction. Medical management appears to have washed out whatever minor impact the gradual risk in medical malpractice claim payments over the last fifteen years might have had on health-care costs."). *See also* Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595 (June, 2002) ("Unlike traditional fee-for-service providers, capitated providers do not have a financial incentive to supply health services of marginal necessity or benefit.").

72. Health Coalition on Liability and Access, Our Goals, *at* http://www.hcla.org/mission.html (last visited Mar. 11, 2006) ("[D]efensive medicine that costs billions, and at times can cause needless suffering.").

73. Peter G. Teichman & Nicholas E. Bunch, *Depositions: Defending Your Care*, FAM. PRAC. MGMT., (July/Aug. 2001), *at* http://www.aafp.org/fpm/20010700/34depo.html ("Professional competency, clear communication and complete documentation build a bulwark against claims of malpractice."). *See also* Peter G. Teichman, *Documentation Tips for Reducing Malpractice Risk*, FAM. PRAC. MGMT., (Mar. 2000), *at* http://www.aafp.org/fpm/20000300/29docu.html (providing a system of documentation that would force physicians to thoroughly explain and document the thought process behind their care; unless this thought process itself were unreasonable, the physician would avoid medical negligence liability).

74. Baker, *supra* note 43, at 118.

be.[75] Distinguishing these types of "defensive medicine" has proven to be elusive.[76] Researchers have had difficulty developing figures that even claim to accurately measure the extent of defensive medicine.[77]

Evidence suggesting that physicians are engaging in this behavior is scant at best. The Wisconsin Supreme Court, citing studies by "three independent, non-partisan governmental agencies," stated that defensive medicine is not significantly contributing to the cost of healthcare.[78] Clinical scenario research has concluded that in only the rarest of occasions would the fear of medical negligence liability have any influence over a physician's medical decision making.[79] Comparative hospital records research has confirmed that defensive medicine in obstetrics, one of the high-risk specialties cited as most likely to engage in defensive medicine, is at most one-half of one percent of the total obstetric costs.[80] The research is clear on this point: if there is so-called "defensive medicine" taking place, defined as tests and/or procedures that are not helpful to the patient, it is not having an impact on the cost of healthcare.[81]

Even if defensive medicine were a problem, cutting back on tort liability does not seem to be reasonably calculated to solve it.[82] The solution is for physicians to practice evidence-based medicine, an outcome that is promoted, not impeded, by medical negligence lawsuits.[83] Unnecessary tests or procedures do not shield physicians from liability; physicians should engage in behavior that is more likely to prevent medical negligence liability, such as reasonable planning and diagnosis, rather than simply ordering procedures or tests that do no more than obfuscate.[84]

III. THE "SOLUTIONS" TO THE "INSURANCE PREMIUM LIABILITY CRISIS," AS ADVANCED BY TORT REFORM PROPONENTS

A. CAPS ON DAMAGES

Proponents of medical negligence tort reform falsely claim that a cap on non-economic damages is the "single most effective way to moderate premiums - it lowers premiums by about fifteen to eighteen percent."[85]

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75. *Id.* at 118-19.
76. *Id.*
77. *Id.* at 119.
78. Ferdon v. Wis. Patients Comp. Fund, 701 N.W.2d 440, 488 (Wis. 2005).
79. Baker, *supra* note 43, at 123-24.
80. *Id.* at 126.
81. *Id.* at 121, 134.
82. *Id.* at 136.
83. *Id.* at 137.
84. Teichman & Bunch, *supra* note 73; Teichman, *supra* note 73.
85. *See, e.g.*, Roberts, *supra* note 11 (discussing the MICRA reforms in California).

Assertions like this, commonly heard in the media from tort reform proponents,[86] are simply false. States with caps on damages have premiums 9.8% *higher* than those without.[87] Representatives of the insurance companies even admit that a cap on damages will not result in lower premiums.[88]

Despite these facts, when signing into law a cap on non-economic damages, Illinois Governor Rod Blagojevich stated, "with this legislation, we're taking a major step forward to make sure that doctors keep practicing in Illinois, and people get the medical care they need."[89] The Governor implied that a cap would keep doctors in Illinois because of its effect on medical negligence insurance premiums. The experience of those states with caps has shown that they have no downward effect on insurance premium rates, serving only to raise profits for insurance carriers.[90] A damages cap does not facilitate experience rating, does not even out pricing by region, or otherwise make medical negligence liability premiums more fair.[91] This is no solution to any perceived "crisis" in medical negligence insurance; it is only a subsidy to insurance companies taken from the pockets of those most seriously injured as a result of proven medical negligence.

Some tort reform proponents falsely point to the MICRA reforms in California as evidence that caps on non-economic damages work to reduce medical negligence insurance premiums.[92] This is not the case. Between 1975 (passage of MICRA) and 1988, insurance premiums increased 450%

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86. *See, e.g.*, Randolph W. Pate & Derek Hunter, *Code Blue: The Case for Serious State Medical Liability Reform*, in EXECUTIVE SUMMARY BACKGROUNDER No. 1908, (Jan. 17, 2006), *at* http://www.heritage.org/Research/HealthCare/bg1908.cfm.

87. Medical Liability Monitor, (Oct. 2004).

88. *See, e.g.*, Foundation for Taxpayer and Consumer Rights, Nation's Largest Medical Malpractice Insurer Declares Caps on Damages Don't Work, Raises Docs' Premiums (Oct. 26, 2004), *at* http://www.iltla.com/Medical%20Malpractice/FTCR_MedMal_10_26_04.pdf. *See also* Kevin J. Conway, Editorial, *Tort Reform Won't Lower Malpractice Premium*, CHI. TRIB., Jan. 11, 2005, at 14 ("Insurance company executives have repeatedly stated that they would not reduce premiums after enactment of caps on non-economic damages.").

89. Press Release, Governor Rod Blagojevich, *Gov. Blagojevich signs medical malpractice reform: Legislation designed to improve access to physician care in Illinois, at* http://www.illinois.gov/PressReleases/PressReleasesListShow.cfm?RecNum=4228 (Aug. 25, 2005).

90. Hebeisen, *supra* note 4.

91. Baker, *supra* note 34, at 440.

92. *See, e.g.*, Cooperative of American Physicians, Inc., MICRA, *Questions and Answers*, *at* http://www.cap-mpt.com/legislative_corner/micra_q_and_a.html (last visited Feb. 3, 2006) ("Eliminating the current $250,000 non-economic damages cap could increase the cost of health care in California by more than $6 billion per year.").

in California and reached an all-time high.[93] It was insurance reform enacted in 1988 that caused insurance rates to stabilize in the intervening seventeen years and caused insurance companies to be forced to refund millions of dollars to insured physicians.[94]

Medical negligence tort reform proponents falsely claim that "runaway juries" are awarding *unreasonably* high amounts of non-economic damages in medical negligence cases.[95] They falsely claim that the institution of a cap on non-economic damages will prevent emotionally-inflamed juries from "punishing" doctors by issuing an unreasonable award.[96] This flawed argument ignores the equitable remedy of remittitur.[97] If an award were truly unreasonably high, the judge would have the discretion to lower the award to a reasonable level.[98] This means that the awards that tort reform proponents truly seek to eliminate are those where the judge has denied a motion for remittitur, thus determining that the verdict was high but reasonable.[99] Reducing high but reasonable awards for damages from proven medical negligence by arbitrary caps only increases the profits of medical negligence insurers by depriving compensation from those who have proven to deserve it most.

A *de facto* cap already exists which restricts medical liability insurance company payouts: the insurance policy limits. With the exception of bad-faith failure to settle claims, insurance companies are only obligated to

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93. Foundation for Taxpayer and Consumer Rights, *How Insurance Reform Lowered Doctors' Medical Malpractice Rates in California: And How Malpractice Caps Failed*, at 1 (Mar. 7, 2003), *at* http://www.iltla.com/Medical%20Malpractice/HowInsuranceReformLowered.pdf.

94. *Id.*

95. *See, e.g.*, Hiran Ratnayake, *Malpractice limits choices for expectant moms in Del.; High cost of insurance premiums in state has forced some doctors to stop practicing their chosen specialty*, THE NEWS-JOURNAL (Wilmington, DE), May 29, 2005, at 1A ("[T]he Physician Insurers Association of America, a group that has member organizations that insure 60% of the nation's physicians, blames rising rates on runaway jury verdicts and frivolous lawsuits.").

96. Bruce L. Allen & Josef E. Fischer, *Caps on malpractice awards: Update*, 84 Bulletin of the American College of Surgeons, No. 6 (June 1999), *at* http://www.facs.org/ahp/proliab/0699a.html.

97. *See, e.g.*, Buckholtz v. MacNeal Hosp., 785 N.E.2d 162, 168-69 (1st Dist. 2003) (Stating that a verdict can be set aside by a court if it is "so excessive as to indicate that the jury was moved by passion or prejudice, or that it exceeds the necessarily flexible limits of fair and reasonable compensation or is so large that it shocks the judicial conscience.").

98. *See, e.g.*, Henry v. St. John's Hosp., 563 N.E.2d 410 (Ill. 1990); Richter v. Northwestern Mem'l Hosp., 532 N.E.2d 269 (1st Dist. 1988).

99. It is also interesting to note that large non-economic damage awards would be money that goes to the patient to compensate him or her for pain and suffering, loss of consortium, loss of quality of life, etc. or to the family of the patient to compensate them for their loss. The major part of the economic damage award goes back into the insurance and healthcare system as past and future medical care needs. Hebeison, *supra* note 4.

pay out the limits of their policy, often as low as $1 million. Since settlements of meritorious lawsuits rarely exceed the insurance policy limits, the limits effectively create a cap on both economic and non-economic damages. Enforcement of a verdict in excess of insurance policy limits is extremely rare. This author is only personally aware of this occurring once in his thirty-eight year career spanning three states.

The same types of arguments regarding the moderation of insurance premium rates were proffered in support of the cap on damages passed in Texas. Prior to the passage of the Texas cap, the Texas Department of Insurance estimated that the measure would save physicians 8.5-11% on premiums.[100] After the passage of the cap, the two largest insurers in the state did not reduce medical negligence insurance premiums but rather sought to raise them by 19 and 35%.[101]

The claims by proponents of caps on non-economic damages can be refuted by basic theories of economics and rational business behavior. The goal of any profit-seeking business is to maximize profit.[102] This goal is accomplished by determining the price at which the firm may maximize revenue, that is, the total amount of money brought in from the sale of their good or service. If this amount is greater than the cost to produce the good, the firm will produce it. If the firm is able to lower costs after it is already engaged in the production of the good, the firm will not lower the price, as it is already set at the revenue-maximizing level. The best ways to induce a firm to lower prices in response to lower costs to produce are competition and regulation.[103]

Insurance companies set their premium rates based upon "what the market will bear."[104] If the companies raised their premium rates beyond the price physicians were willing to pay, they would not be rationally maximizing their revenues. For insurance companies to blame the price increases on medical negligence litigation is disingenuous considering economic theory and rational business decision-making.

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100. Illinois Trial Lawyers Association, *Medical Malpractice, Insurance and Doctor Discipline Issues* at 4 (Feb. 2005), *available at* http://www.iltla.com/Medical%20Malpractice/ITLA_med_mal_position_paper_05.pdf.

101. *Id.*

102. *See generally* ADAM SMITH, AN INQUIRY INTO THE NATURE & CAUSES OF THE WEALTH OF NATIONS (1776). *See also* HOWARD S. DYE ET AL. ECONOMICS: PRINCIPLES, PROBLEMS, AND PERSPECTIVES 324 (1962); CAMPBELL R. MCCONNELL, ECONOMICS: PRINCIPLES, PROBLEMS, AND POLICIES 85 (1978).

103. DYE et al., *supra* note 102, at 328.

104. MCCONNELL, *supra* note 102, at 372 (discussing rational decision-making in oligopoly situations).

B. CHANGES TO SECTION 2-622 (CERTIFICATE OF MERIT)

Section 2-622 of the Illinois Code of Civil Procedure was designed to restrict potential plaintiffs' access to the courts by reducing "frivolous" lawsuits.[105] This provision was made effective as of August 15, 1985. The prior version of this statute allowed plaintiffs to redact the reviewing physician's name and address when submitting the certification and required an affidavit from the submitting attorney that he or she had consulted with a licensed physician.[106] The change in this provision mandating the disclosure of the plaintiff's consulting expert has no logical connection to preventing frivolous lawsuits over and above the effect that the previous version had. The assertion by the sponsor of the tort reforms overturned by *Best v. Taylor Machine Works*[107] stated that the reason for the disclosure requirement was to "reduce the systemic cost of tort recovery."[108] This argument makes no sense. Forcing plaintiffs to contact additional experts willing to disclose their names, addresses, and license numbers, reduces the number of physicians available to certify these cases, which are especially unpopular among physicians. Decreased supply of a commodity or service tends to cause an increase in the price charged for that commodity or service.[109] Reducing the supply of physicians willing to certify cases increases the cost of tort recovery, reduces the amount recovered by injured patients, and reduces their access to the courts. Disclosure of the name, address, and license number of a physician certifying cases against physicians in these emotionally-charged lawsuits makes it more likely that physicians willing to assist plaintiffs in recovering for their injuries caused by medical negligence will be ostracized by some of their peers.[110]

105. DeLuna v. St. Elizabeth's Hosp., 588 N.E.2d 1139, 1142 (Ill. 1992) ("Section 2-622 is designed to reduce the number of frivolous suits that are filed and to eliminate such actions at an early stage, before the expenses of litigation have mounted.").

106. 735 ILL. COMP. STAT. 5/2-622 (2003).

107. 689 N.E.2d 1057 (1997).

108. Kirk W. Dillard, *Illinois' Landmark Tort Reform: The Sponsor's Policy Explanation*, 27 LOY. U. CHI. L.J. 805, 810 (1996).

109. *See generally* ADAM SMITH, THE WEALTH OF NATIONS (1776).

110. *See, e.g.*, Medical Justice Corp., http://www.medicaljustice.com (last visited Mar. 9, 2006). Medical Justice is an organization that seeks to obtain license suspensions and removal of physicians from medical associations for testifying against its members in a "frivolous" fashion; this organization does not seek punishment of physicians who testify falsely or fraudulently on behalf of defendant physicians. Michael J. Sacopulos, *Addressing False Expert Witness Testomony in Medical Malpractice Litication*, 9 HEALTH LAWYERS NEWS 5 at 24 (May 2005) (discussing "hired gun" expert witness testimony).

Intimidation and censure of plaintiff expert witnesses by neurology and neurosurgery organizations has frequently occurred, directed solely against plaintiff experts and never against defense experts.

> Neurologists who testify in court are coming under tighter scrutiny by medical authorities who are seeking to weed out unqualified witnesses from the courtroom. In a move that has irked plaintiffs' attorneys, the American Academy of Neurology (AAN) recently revamped its 16-year-old guidelines regarding expert witness testimony by neurologists. The new guidelines were formally adopted earlier this year, but will not go into effect until Jan. 10, 2006. The AAN maintains that the guidelines, which call for tougher expert credentials and warn against doctors advocating for lawyers, are a response to several complaints by physicians about unqualified witnesses.[111]

There is no empirical evidence that measures like ILCS 5/2-622 in any form have provided benefit to any participant in the medical negligence tort system, but evidence does exist that measures like Section 2-622 cause significant costs to be incurred.[112] The substantial and increased costs incurred to gain access to the courts, which are born by plaintiffs, restricts less severely-injured plaintiffs from access to the courts. ILCS 5/2-622 has been in existence for more than twenty years, yet there is no objective evidence that this onerous burden to plaintiffs has improved the medical negligence tort system.

C. FURTHER RESTRICTIONS ON EXPERT WITNESSES

Public Act 94-677 prescribed further restrictions on who could testify on behalf of an injured plaintiff as an expert witness.[113] Presently, the court must consider whether an expert is board-certified, board-eligible, or has completed a residency in the same or substantially similar specialty as the defendant.[114] The expert must now be dedicating a majority of their work time to the specialty, either practicing, teaching, or researching.[115] The expert must provide evidence of active practice and that they have the same class of license as each defendant. If the expert is retired, they must show

111. Tresa Baldas, *Move to Crack Down on Expert Witnesses*, NATIONAL L. J. (Dec. 19, 2005).

112. Jeffrey A. Parness & Amy Leonetti, *Expert Opinion Pleading: Any Merit to Special Certificates of Merit?*, 1997 BYU L. REV. 537, 577.

113. 2005 Ill. Laws P.A. 94-677 (modifying 735 ILL. COMP. STAT. 5/8-2501).

114. *Id.*

115. *Id.*

that they have completed medical education courses for the three years preceding their testimony, and if they have been retired for five years, they cannot testify.[116]

These restrictions purport to eliminate frivolous testimony but in reality only restrict plaintiffs' access to the courtroom by making litigation more expensive for plaintiffs by reducing the pool of available expert witnesses and increasing the number of expert witnesses required. In cases against multiple defendants, the plaintiff would need separate certifications for each defendant, each of which would likely add $1,000 or more to the cost for filing a claim. Expert testimony and deposition costs would increase by the number of physicians with different specialties, costs which are not taxable to negligent defendants when a plaintiff achieves a verdict.[117] These additional restrictions provide defendants with grounds to object to expert witnesses based on proofs as to the status of their practices and continuing education, lengthening the litigation process and further increasing the costs to plaintiffs. The effect of these new provisions will result in more litigation, not less, just as the original version of Section 2-622 has.[118] The provisions regarding retired physicians are to be applied as of the date of testimony; if an expert physician retires during the pendency of a case, and the defense is successful in delaying the case for five or more years (not uncommon in large medical negligence cases), plaintiffs would lose their expert witness, bear the substantially increased costs for duplicate experts, and may be unable to succeed in their claim.[119]

D. OTHER DIFFICULTIES UNIQUE TO MEDICAL NEGLIGENCE CASES

These "reforms" are in addition to the burdens already placed on medical negligence plaintiffs vis-à-vis other tort plaintiffs. Medical negligence plaintiffs bear the additional expense of proving their cases only through expert witnesses except in cases of gross negligence.[120] Medical negligence plaintiffs face restrictions on discovery[121] and restrictions on their ability to contract with plaintiffs' attorneys.[122]

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116. *Id.*

117. Vicencio v. Lincoln-Way Builders, Inc., 789 N.E.2d 290, 294-95 (Ill. 2003).

118. The term "2-622" currently appears in 177 published appellate decisions and the sufficiency of a 2-622 certificate of merit is a standard motion presented by most defendants in medical negligence cases.

119. Walski v. Tiesenga, 381 N.E.2d 279, 282-83 (Ill. 1977) (expert testimony required to establish prima facie case).

120. *Id.*

121. *See* Medical Studies Act, 735 ILL. COMP. STAT. 5/8-2101 (2004).

122. *See* 735 ILL. COMP. STAT. 5/2-1114 (2004).

E. NATIONAL MEDICAL NEGLIGENCE TORT REFORM PROPOSALS

Congress is currently considering a federal tort reform package that would restrict medical negligence liability for insurance companies at a cost to the most severely-injured patients.[123] President George W. Bush made medical negligence tort reforms like this bill a part of his State of the Union address on January 31, 2006.[124] His bill would limit non-economic damages to a maximum award of $250,000 and limit punitive damages to cases where the plaintiff can prove intentional wrongdoing, and would be limited to $250,000 or double the economic recovery, whichever is greater.[125] The bill would also restrict plaintiffs' attorneys' fees (but have no effect on defense attorneys' fees), abolish joint-and-several liability, allow evidence of collateral sources at trial, and allow defendants to pay claims gradually over time.[126] Each of these measures restricts access to the courtroom or lowers money received by patients to the benefit of medical negligence insurance carriers. That restrictions on attorney fees would apply only to plaintiffs and not defendants is telling. Assuming *arguendo* that the quality of attorneys is related to the fees charged for their services, this bill would allow for fair compensation for quality defense attorneys but not for quality plaintiffs' attorneys, who would either be paid less or who would decline to represent plaintiffs in these cases. As experience with the MICRA reforms in California and simple economic analysis shows, the savings, if any, will not be passed on to the consumer (physicians and their patients) but rather will be retained as profits.[127]

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123. Health Law Colloquium, *supra* note 1, at 515 (citing H.R. 5, the "Help, Efficient, Accessible, Low-Cost, Timely Healthcare" (HEALTH) Act of 2003).

124. President George W. Bush, State of the Union Address, *available at* http://www.usatoday.com/news/washington/2006-01-31-sotu-text_x.htm (Jan. 31, 2006) ("And because lawsuits are driving many good doctors out of practice, leaving women in nearly 1,500 American counties without a single OB-GYN, I ask the Congress to pass medical liability reform this year.").

125. Health Law Colloquium, *supra* note 1, at 515. Punitive damages are already proscribed in Illinois for healing arts malpractice cases. 735 ILL. COMP. STAT. 5/2-1115 (2003).

126. Health Law Colloquium, *supra* note 1, at 515.

127. *See* Illinois Trial Lawyers Association, *Medical Malpractice Talking Points*, *available at* http://www.iltla.com/Medical%20Malpractice/medmal_talking_points.PDF (last visited March 27, 2006).

IV. THE REAL PROBLEMS - EPIDEMIC MEDICAL NEGLIGENCE AND UNFAIR INSURANCE COMPANY PRICING

A. MEDICAL NEGLIGENCE IS EPIDEMIC

Injuries from medical negligence are epidemic in the United States. Ninety-eight thousand people die each year from medical errors in hospitals alone.[128] This figure does not include those who die from adverse drug interactions or those who die from medical errors in physicians' offices, nursing homes, or ambulatory care centers.[129] The Harvard Medical Practice Study examined hospitals in New York State and found that 2.1% of all hospitalized patients were injured due to medical error, causing disability or extended hospital stays.[130] Patients are dying from preventable medical errors in hospitals at an alarming rate, and the costs to society from these deaths are staggering. Roughly 1,942 to 4,325 Illinoisans die each year from preventable medical errors in hospitals.[131]

Medical negligence is the problem, not plaintiffs' attorneys or the legal system which expose only a small portion of this negligence and its consequences. The cause of the medical negligence epidemic is the frequent negligent conduct of the healthcare providers: physicians and hospitals. Medical negligence lawsuits provide a harsh spotlight on this tragic and continuing epidemic of negligently-caused injuries and deaths throughout this country. Injured patients and their lawyers are the vocal messengers of this tragic problem, and solutions designed to muzzle the message will only exacerbate this epidemic of medically-induced, negligent injuries and deaths.

The loss to the economy from injuries caused by medical negligence dwarfs the total amount of medical negligence liability payouts.[132] "Injured patients and their lawyers are the messengers here, not the cause of the medical malpractice problem."[133] The general level of medical negligence premiums is far lower than it would be if patients could efficiently utilize the tort system to receive just compensation for their injuries.[134]

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128. The Institute of Medicine, *To Err is Human: Building a Safer Healthcare System* (2000) [hereinafter *To Err*].

129. *Id.*

130. Health Law Colloquium, *supra* note 1, at 511.

131. Center for Justice and Democracy, http://www.centerjd.org/TestimonyIL050223.pdf#search='1%2C942%204%2C325%20medical' (extrapolating from *To Err*, *supra* note 128.). This figure also does not include deaths from medical errors in doctor's offices, ambulatory care centers, drug interactions, and nursing homes.

132. Geistfeld, *supra* note 12, at 443.

133. Baker, *supra* note 43, at 3.

134. Geistfeld, *supra* note 12, at 444.

The patient safety problem is not improving. There were an estimated 7,000 deaths in 1993 due to adverse drug interactions.[135] In 1983, ten years earlier, there were only 2,876.[136] One to two percent of all patients admitted to a hospital encounter a preventable adverse drug event, which increases the cost of healthcare by an average of $4,700 per admission.[137] Each dollar spent on ambulatory medications leads to another dollar spent to treat the new health problems caused by the medications.[138] A patient today is 36% *more likely* to get infected at the hospital than they were in the 1970s.[139]

These trends in medical negligence are much worse than the results seen in other industries where safety concerns led to improvements. The commercial airline industry has made it four times less likely that a passenger will die in a domestic flight between the 1960s and 1970s and 1990.[140] The death rate from workplace injuries has been cut in half between 1970 (when OSHA was created) and 1996.[141] Anesthesiologists have reduced their mortality rates from 2 per 10,000 to 1 per 200,000-300,000.[142] They accomplished this through: 1) technological changes; 2) information, especially guidelines and standards; 3) better training, including simulators; and 4) formation of a foundation to provide leadership and direction for research.[143]

Several factors account for this problem. There are insufficient positive economic incentives in place to encourage high-quality care and some that may discourage high-quality care. Unlike traditional fee-for-service providers, providers paid "per capita" have no financial incentive to supply health services of marginal necessity or benefit.[144] The capitated physician paid "per capita" is paid the same amount no matter how much time the physician spends with the patient, how diligent the physician is with follow-up, or how many and how extensive the tests and/or procedures the physician performs or orders. Capitation agreements create economic disincentives for doctors to perform beneficial tests or procedures, as the cost for these would come directly out of the profit margin of their practice.[145]

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135. *To Err*, *supra* note 128, at 27.
136. *Id.* at 26-27, 32.
137. *Id.* at 27.
138. *Id.* at 41.
139. Betsy McCaughey, *Hospitals' Dirty Little Secret: Infections Now Are Rampant*, INVESTOR'S BUS. DAILY, Aug. 2, 2002, at A16.
140. *To Err*, *supra* note 128, at 71.
141. *Id.* at 73.
142. *Id.* at 144-45.
143. *Id.* at 144-45.
144. Mello & Brennan, *supra* note 71, at 1595.
145. *Id.* at 1595.

Hospitals are faced with economic disincentives to improve quality of care and to discover and disclose system failures and poorly-trained personnel. A physician who handles a large number of patients is more profitable for a hospital, but often creates the greatest medical negligence. Hospitals lack the incentive to train their physicians or improve the delivery system for healthcare as these activities would take physicians away from revenue-producing patient care. Insufficient economic incentives exist to encourage high-quality care and to discourage low-quality care.

Oversight of physicians outside of the hospital setting is under-funded and woefully limited. Negligent doctors have little risk from the licensing boards of Illinois. The Department of Professional Regulation took action against only 34 of 39,000 practicing physicians for incompetence, negligence, or gross misconduct in 2002.[146] Since a license to practice medicine is a state-controlled monopoly, the usual laws of supply and demand are not operational. The supply of physicians is limited by the state's licensing of physicians. The supply of medical specialists is tightly controlled by the American Board of Medical Specialties, which controls the number of training programs, the number of doctors permitted to train in those programs, and by its examination systems, the number of specialists in every area. If a shortage of physicians and specialists exist, increasing the number of physicians is the obvious solution, not limiting their liability for proven negligence.

Insufficient negative economic incentives exist to discourage low-quality care. Demand for physicians' services does not decrease based on the poor quality of care; in fact, the opposite seems to be true.[147] Medical negligence tort measures, limiting access to the courtroom and reducing just compensation paid to patients injured by negligent physicians, decreases the economic incentives for improvement in healthcare services even further, endangering rather than protecting the safety of the patient. "[A]ll the research that has been done so far points in the same direction: tort reform does not improve health-care outcomes. If anything, the research suggests that at least some kinds of tort reforms might have a detrimental effect on health . . . ."[148]

Caps on non-economic damages sends a mixed message to healthcare providers and organizations. Rather than improve the quality of care and reduce the frequency and severity of injuries, the costs of these injuries will be born by the most severely injured rather than the negligent tortfeasor.

146. Illinois Trial Lawyers Association, *Medical Malpractice, Insurance and Doctor Discipline Issues, available at* http://www.iltla.com/Medical%20Malpractice/ITLA_med_mal_position_paper_05.pdf (last visited Mar. 27, 2006).

147. *See* Mello & Brennan, *supra* note 71, at 1595.

148. Baker, *supra* note 43, at 148.

The Wisconsin Supreme Court, while invalidating that state's non-economic damage cap, stated, "it is a major contradiction to legislate for quality medical care on one hand, while on the other hand, in the same statute, to reward negligent healthcare providers."[149]

Reducing the incentive for injured patients and plaintiffs' lawyers to file lawsuits punishes the injured patient and her messenger to the benefit of the negligent healthcare provider and its insurer.[150] Factors which highlight the current medical negligence epidemic can only extend the problem and delay solutions to the source of the medical negligence epidemic: the negligent conduct of physicians and hospitals.

B. INSURANCE UNDERWRITING CYCLE

The high cost of medical liability insurance is a problem which requires a solution. The solution, in addition to reducing the incidence of medical negligence injuries, lies in examining the basis for exorbitant medical liability insurance premiums. Medical negligence liability insurance premiums track closely with the stock market and with the profits earned by insurance companies from their investments. "The insurance underwriting cycle is an insurance industry-specific business cycle that consists of alternating periods in which insurance is priced below cost (a 'soft market') and periods in which insurance is priced above cost (a 'hard market')."[151] Insurance companies make most of their money by investing the premiums from policies sold.[152] The soft market occurs during a period of high investment market returns, when insurance companies are fiercely competing for premium dollars to invest in these favorable conditions.[153] The soft market occurs during a period of high investment market returns, when insurance companies are fiercely competing for premium dollars to invest in these favorable conditions.[154] When investment income decreases, the industry responds by raising prices and reducing coverage, calling the phenomenon a "liability insurance crisis."[155] This natural cycle in the insurance industry gives rise to unfair pricing cycles for physicians and gives insurance companies the opportunity to blame the price increases on

149. Ferdon v. Wis. Patients Comp. Fund, 701 N.W.2d 440, 464 (Wis. 2005).

150. Baker, *supra* note 43, at 3.

151. Baker, *supra* note 34, at 396.

152. *Current Issues Related to Medical Liability Reform: Before the Subcommittee on Energy and Commerce*, 109th Cong. 3 (2005) (statement of J. Robert Hunter, Director of Insurance).

153. *Id.*

154. *Id.*

155. *Id.*

factors outside the insurance community, particularly the medical negligence tort system.

V. WHAT SHOULD BE DONE: REAL SOLUTIONS

A. DEMAND FOR PHYSICIANS AND MEDICAL NEGLIGENCE LIABILITY INSURANCE RATES MUST VARY BASED ON QUALITY OF CARE

The limited availability of information regarding the quality of care delivered by physicians limits the ability of patients to evaluate and identify physicians who provide poor quality of care. As one author stated the problem, "[T]he available data suggests that there is not much elasticity of demand associated with perceptions of quality in healthcare. In fact, the evidence seems to suggest the opposite."[156] In order for the public to be able to choose doctors based on their quality of care, information about the conduct of individual physicians must be available to patients when choosing their physician. A small proportion of doctors are responsible for the lion's share of medical negligence payouts. In Illinois, 3.6% of the practicing doctors are responsible for 47% of the medical negligence payouts.[157] If this information were available to patients when they were making their physician choices, it is likely that these 3.6% of doctors would see their patient base decrease substantially.

Improved credentialing, surveillance of physician conduct, and monitoring of physician results by insurance companies and governmental agencies can assist in identifying problem physicians who cause patient injuries. Providing payments to healthcare providers based upon their results rather than simply according to the service performed or procedure performed will create an incentive for physicians to perform these services carefully, and would penalize careless physicians. Simply increasing the payment to a physician whose record is that of safety while decreasing the payments to physicians with poor records will create a strong incentive for careful thought and planning in the provision of healthcare services. The present system does not reward high quality of care nor penalize poor quality of care. The present payment system ignores the laws of capitalism.

Physicians who provide high quality of services pay the same medical liability insurance premiums as physicians who provide poor healthcare services. "Good doctors" should pay reduced medical negligence premiums, while negligent physicians who provide poor quality of care services should pay higher premiums, or for the worst doctors, not be provided

156. Mello & Brennan, *supra* note 71, at 1597.

157. Illinois Trial Lawyers Association, at http://www.iltla.com/Medical%20Malpractice/ITLA_med_mal_position_paper_05.pdf at page 11 (citing the National Practitioners' Databank).

insurance at all. The present system does not distinguish or even identify these healthcare provider groups, except in the worst cases. An individual physician's medical negligence history, settlement payments, and history of disciplinary actions by hospitals or licensing boards are not particularly influential in determining medical negligence liability insurance premiums.[158] Nationwide, 54% of the payouts for medical negligence have resulted from the conduct of 5% of physicians.[159] These high-risk physicians do not encounter the proportionate increase in insurance premium that any accident-prone automobile driver would, increases that would make business and actuarial sense.[160] Instead, the risk attributable to these high-risk individuals is spread to, and paid for by, the other members of their specialty.[161]

Insurance companies rate their physician medical negligence insurance clients based on location of practice, specialty, and years of practice rather than their own history of medical negligence or the nationwide averages for medical negligence in their specialty.[162] This has resulted in uneven premium rates, especially for doctors in rural areas.[163] This unfair pricing policy has exacerbated the longstanding problems associated with providing adequate access to healthcare in rural areas. It is insurance company pricing policies that are affecting access to medical care, not "greedy lawyers" and "runaway juries."

B. IMPROVE THE QUALITY OF THE PHYSICIAN WORKFORCE THROUGH INVESTIGATION AND NEUTRAL PEER REVIEW

Medical errors in hospitals cause at least 98,000 deaths per year.[164] This is more than the deaths caused from motor vehicle accidents, breast cancer, or AIDS. Medical errors in hospitals are the eighth-leading cause of death in the United States.[165] This number does not include the non-fatal injuries that occur to nearly 3% of all hospital patients.[166] The total cost to the economy for preventable adverse events is $17-29 billion per year.[167] Compare the figures above with the 6,000 annual deaths from workplace injuries.[168] And yet, OSHA[169] has 2,100 inspectors, plus additional

158. Gunnar, *supra* note 19, at 471-72.
159. *Id.*
160. *Id.* at 472.
161. *Id.*
162. *Id.* at 471.
163. *Id.* at 473.
164. *To Err*, *supra* note 128, at 1.
165. *Id.* at 26.
166. *Id.* at 1.
167. *Id.* at 27.
168. *Id.* at 2.

investigators, engineers, physicians, educators, standards writers, and other technical and support personnel,[170] while the Department of Professional Regulation[171] has only 248 total employees to investigate around one million licensed professionals in Illinois.[172] Nationwide, sanctions from licensing boards are relatively rare[173] and are an extreme culmination of the recognition of unprofessional behavior.[174] The sanctioning rate of physicians is even lower in Illinois.[175] Studies have shown that those physicians that are disciplined by licensing boards are twice as likely to have failed a course in medical school, have lower MCAT scores, undergraduate science grade-point average, and NBME scores, and three times as likely to have demonstrated unprofessional behavior in medical school.[176] Additional investigation is needed, but could be made more efficient by more carefully monitoring those physicians with the criteria enumerated above. As stated by the Institute of Medicine, "the health system has not had effective ways of dealing with dangerous, reckless, or incompetent individuals and ensuring that they do not harm patients."[177]

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169. The Occupational Safety and Health Administration is a federal agency with a mission to "assure the safety and health of America's workers by setting and enforcing standards; providing training, outreach, and education; establishing partnerships; and encouraging continual improvement in workplace safety and health." Occupational Safety and Health Administration, *Mission Statement*, *at* http://www.osha.gov/oshinfo/mission.html (last visited Mar. 27, 2006).

170. *Id.* This number is nationwide; the number that could be attributed to Illinois, based on Illinois' percentage of the national population, could be said to be around ninety-one (population figures from www.census.gov).

171. This is the licensing and disciplinary body that covers physicians along with many other professions, such as private investigators and insurance agents.

172. The Department of Professional Regulation monitors, licenses, and disciplines a wide variety of professions. Since they oversee "nearly one million professionals," http://www.idfpr.com/NEWSRLS/FactSheet.pdf, and since there are 39,000 practicing physicians in Illinois, http://www.iltla.com/Medical%20Malpractice/ITLA_med_mal_position_paper_05.pdf, it would follow that 39,000/1,000,000, or approximately 3.9%, of their staff would be involved in the oversight of physicians. Thus, it follows that there are ten total employees monitoring the 39,000 practicing physicians in Illinois.

173. Approximately 0.3% of practicing physicians, or three per one-thousand, have disciplinary action taken against them by licensing boards. This likely reflects the most extreme forms of unprofessional behavior. Maxine A. Papadakis et al., *Disciplinary Action by Medical Boards and Prior Behavior in Medical School*, 353 NEW ENG. J. MED. 2673 (2005).

174. Lynne M. Kirk & Linda L. Blank, *Professional Behavior – A Learner's Permit for Licensure*, 353 NEW ENG. J. MED. 2709 (2005).

175. The Department of Professional Regulation took action against only 34 of 39,000 practicing physicians for incompetence, negligence, or gross misconduct in 2002. This is less than one per thousand, or one-third the national rate.

176. Papadakis et al., *supra* note 173, at 2676.

177. *To Err*, *supra* note 128, at 169.

Identifying physicians who provide high-quality care and, as importantly, physicians and hospitals that provide poor-quality care is critical to any real solution to the medical negligence epidemic. At present, patients are provided limited access to information regarding the identity of providers of high or poor-quality care. For the marketplace forces to work effectively, adequate information about physicians who are subjected to peer-review sanctions, physicians who have had hospital privileges revoked or limited, state investigations of patient complaints, and lawsuit settlements must be available. Reporting of quality of care parameters for hospitals should be mandatory, identifying which hospitals have the lowest mortality rates, lowest infection rates, and lowest morbidity rates for medical and surgical conditions. The economic forces of patient selection of providers should be permitted to work, which will help reduce the number of physicians who provide the bulk of medical negligence injuries and litigation.

Improved hospital-based peer review methods are necessary to identify physicians who provide negligent healthcare services. Peer review (mortality and morbidity committees) are currently conducted within the hospital or healthcare center where the adverse event occurred. This review is currently conducted by the physician or health professional's colleagues, friends, co-workers, and/or supervisors. Friends, colleagues, co-workers, and supervisors naturally find a conflict in criticizing those with whom they work.[178]

Other models would likely reduce or eliminate conflicts of interest. Peer review can be conducted by demographically-comparable hospitals in distant cities and states in communities similar to the hospital being reviewed. Peer review can be performed by physicians and nurses who have no contact, no loyalties, and no bias in favor of those being reviewed, leading to an analysis of care that is more objective. Data which specifically identifies the name of the patient and the healthcare provider can be deleted from the records reviewed. More stringent and effective review is likely and correction of errors in conduct or in the systems and/or procedures are more likely, which may lead to the more rapid discovery of impaired physicians. These corrections would result in better health outcomes for patients and reduced injuries. There would be no additional cost to healthcare providers for this model, as they are already performing peer review functions. The only difference would be that the reviewing

178. In psychology terms, there are two biases at play in this situation. The first is called "ingroup bias" and the second is called "mere exposure bias." These psychological theories basically state that one looks more positively on that with which they are familiar. *See, e.g.*, Robert B. Zajonc, *Attitudinal Effects of Mere Exposure*, J. PERSONALITY & SOC. PSYCHOL. MONOGRAPH SUPPLEMENT, (June 1968), at 1, 9.

would be of the conduct and systems from another medical care center instead of their own. Candor and honesty in these peer reviews should be encouraged, which could be accomplished by maintaining the privilege over the substance of these reviews.[179]

C. INCREASE THE NUMBER OF PHYSICIANS AND SPECIALISTS

In order to encourage the medical profession to examine its methods and procedures, the public must create the economic incentives for it to do so. Restoring the effects of supply and demand on physician services can work to allow marketplace forces to identify and reward physicians who provide quality care. Increasing the supply of physicians would provide patients the opportunity to make choices based upon quality of care rather than simple availability. The limited availability of physicians rather than quality of care delivered reduces the incentive of patients to choose quality physicians. Restoring the laws of supply and demand permits economic forces to reward the quality physicians and to penalize physicians who are careless and commit medical negligence. By increasing the supply of physicians and specialists, patients would be able to select their doctors based upon their quality of care, their ability to communicate, their actions in promoting well being, and their training, education, and experience. By traditional standards, shortages of physicians generally do not exist. By increasing the supply of physicians and specialists, not only will local shortages be reduced or eliminated, but patients will have the ability to select physicians based upon quality of care issues rather than simple availability and proximity to home or work. Real economic incentives would be created for physicians to practice high-quality care and reduce unnecessary errors and medical negligence.

D. EMPHASIZE RISK MANAGEMENT

Current standard-setting authorities are not devoting adequate attention to patient safety issues.[180] Risk management measures can be implemented by physicians and healthcare providers to increase the quality of care and decrease the incidence of preventable injury. These measures can be

179. *See* Brian A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 AM. J.L. & MED. 501, 503 (2004) ("The present legal landscape . . . prevents such communication in the healthcare industry. The adversarial nature of our legal system punishes candor and rewards the manipulation of fact, thus discouraging open and honest communication of system issues.").

180. *To Err*, *supra* note 128, at 151.

patterned after those put into practice by anesthesiologists in the 1980s.[181] What these specialists did was identify the causes of most claims against them and implement strategies and standards to avoid them.[182] These practices resulted in a sharp drop in the incidence of injury, negligence suits, and costs for medical negligence liability insurance.[183] Other areas of medical practices have not undertaken these steps to ensure patient safety. Patients are 36% *more likely* to contract an infection in a hospital today than they were in the 1970s.[184] Further, 7,000 people may be dying each year from preventable adverse drug events;[185] this is in addition to the 98,000 patients that die each year from preventable medical errors.[186] Many of the preventable medication errors would have been caught by computerized systems, which hospitals have been slow to implement.[187] Doctors make mistakes, but it is important that the profession examine its standards and procedures as anesthesiologists have done in order to minimize the incidence of these costly errors.[188] The Institute of Medicine agrees that guidance is necessary: "[f]or safe and efficient production, . . . there is . . . a need . . . [for] reasonable work schedules . . . [and] clear guidance on desired and undesired performance."[189]

Educating physicians to develop relationships with their patients will promote improved quality of care. Promoting good communication with patients, colleagues and staff, sustaining clinical competence, and maintaining accurate and legible charts can go a long way toward reducing liability risk.[190]

E. REQUIRE DISCLOSURE OF UNREVEALED CONFLICTS OF INTEREST

Under the fee-for-service model of patient care, a physician who recommends a procedure or operation and who will be paid for those services had a disclosed conflict of interest which is readily apparent to the patient.

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181. Insurance Information Institute, *Hot Topics and Issues Updates: Medical Malpractice*, *at* http://www.iii.org/media/hottopics/insurance/medicalmal/ (last visited Mar. 27, 2006) (describing anesthesiologists' risk-management measures).

182. *Id.*

183. *Id.*

184. McCaughey, *supra*, note 139.

185. *To Err*, *supra* note 128, at 27.

186. *Id.* at 1.

187. *Id.* at 60.

188. Chantal M.L.R. Brazeau, *Coping With the Stress of Being Sued*, FAM. PRAC. MGMT, May 2001, at 41, *available at* http://www.aafp.org/fpm/20010500/41copi.html (last visited Jan. 6, 2006).

189. *To Err*, *supra* note 128, at 60.

190. Richard G. Roberts, *Seven Reasons Family Doctors Get Sued and How to Reduce Your Risk*, FAM. PRAC. MGMT, (Mar. 2003), at 29, at http://www.aafp.org/fpm/20030300/29seve.html.

Aware of the disclosed conflict of interest, the patient has the option of seeking additional opinions and referrals, and he can protect himself accordingly. Under the HMO model of patient care, a "gate-keeper" primary care physician is often paid a bonus based upon the presence of remaining funds which have been allocated for his group of patients. Any money not spent for hospitalization, tests, and procedures is often paid as a bonus to the "gate-keeper" physician. When the gate-keeper physician is aware of a test, procedure, or treatment which might be reasonable for the patient's care but does not choose that treatment for his patient, the physician has a real conflict of interest which is not readily apparent to the patient unless disclosed. Legislation should be created to mandate that all reasonable treatment options be explained to the patient, so that the patient can make an informed decision. Injuries and deaths have occurred as a result of the failure of HMO patients to be provided full disclosure of all reasonable treatment options.[191]

F. INSURANCE REFORM

Insurance reform, while important in reducing insurance costs, will have little or no effect on the important goal of patient safety.[192] A coordinated alignment of regulatory, economic, and professional incentives along with public perception and external features such as the legal realm will have the best chance of improving patient safety and may have some effect on the cost of healthcare services.[193] Changes to the medical negligence insurance industry, such as removing the anti-trust exemption to allow more fair competition, regulating the pricing schemes of the insurance companies, and curbing the misleading accounting practices of the insurance companies will help align these incentives.

1. Eliminate Antitrust Exemption for Medical Negligence Liability Insurance

The "Medical Malpractice Insurance Antitrust Act of 2003" seeks to remove the advantages given to insurance companies through exemptions from anti-trust regulations provided in the McCarran-Ferguson Act.[194] The Act would do away with insurance companies' ability to engage in price-fixing, bid rigging, and market allocations in connection with the business

191. *See, e.g.*, Hinterlong v. Baldwin, 720 N.E.2d 315, 316-17 (Ill. App. Ct. 1999) (describing HMO capitation agreements).

192. *To Err*, *supra* note 128, at 21.

193. *Id.*

194. Anawis, *supra* note 14, at 314.

of providing medical negligence liability insurance.[195] That insurance companies have been able to achieve the passage of a law allowing them to engage in anti-competitive conduct serves as a testament to their lobbying strength. Insurance companies must be forced to compete with other insurance companies, for it is through competition that efficiency is maximized and the fair price is reached.[196]

2. Regulate the Insurance Industry's Pricing Schematics

The Illinois Department of Insurance has never rejected a rate increase in its thirty-one years of operation.[197] The recent passage of P.A. 94-677 gave Illinois regulators the authority to reject medical negligence liability insurance premium increases.[198] The Act calls for an automatic hearing if 1% of the insureds within a specialty or 25% of all insureds so request, or if the rate increase being considered exceeds 6%.[199] It remains to be seen whether this authority will have teeth or amount to little more than a "rubber stamp."

Illinois insurers enjoy the most lax insurance regulation in the United States.[200] By some accounts, Illinois' lack of regulation allows insurance companies to avoid a public review of their financial accounts while simultaneously engaging in price gouging (in an anti-competitive manner) of physicians and healthcare providers and then blaming the high premiums on misleading claims of overly-litigious plaintiffs.[201] Insurance companies are currently able to set pricing policies that are unfair to particular regions.[202] Insurance companies should be forced to establish pricing schematics that set premium rates equitably.

3. Proscribe Insurance Companies' Misleading Accounting Practices

Medical negligence liability insurers inflated their costs (payouts for medical negligence claims) by an average of 46% each year between 1986 and 1994, according to a study released by the nonprofit, nonpartisan

195. *Id.* at 314.
196. *See* Smith, *supra* note 102.
197. Hebeisen, *supra* note 4.
198. *Id.*
199. 215 ILL. COMP. STAT. 5/155.18 (2005).
200. Douglas C. Nelson, *Debate Over Medical Malpractice Liability Heats Up*, 17 LOY. CONSUMER L. REV. 361, 365 (2005).
201. *Id.*
202. Kenneth T. Lumb, *Regulate Insurance to Fight Malpractice 'Crisis'*, CHI. TRIB., Jan. 16, 2005.

Foundation for Taxpayer and Consumer Rights.[203] This was done was by projecting an amount that they expected to pay for future claims (so-called "incurred costs") that was wildly out of proportion to the payouts they actually would make.[204] They would then use these overstated figures as evidence that insurance premiums for doctors needed to be increased and in support of their claims that the "medical negligence liability insurance crisis" necessitated wholesale medical negligence tort reform.[205] The Foundation for Taxpayer and Consumer Rights concluded that the rate increases were neither justified nor necessary and that this accounting practice was utilized for the purpose of justifying unnecessary rate hikes and for pressuring legislatures to enact measures to boost their profits even farther.[206]

VI. CONCLUSION

High medical negligence liability insurance costs are primarily the result of an epidemic of injuries from medical negligence by healthcare providers. The costs of these injuries are staggering. The cost of medical negligence litigation can be best addressed by reducing the frequency of negligent conduct by physicians and hospitals. Improvements in supervision of physicians, medical service payments and medical liability insurance premiums which reward high quality of care and penalize negligent care, and improved peer review of physicians by government, insurers, and hospitals can improve the quality of care delivered to patients and can reduce the frequency and severity of patient injuries. Popular myths have been promulgated which are false, misleading, and will not solve the problem of medical negligence or the high costs of medical liability insurance premiums. Statutory attempts to limit medical negligence lawsuits will have minimal effects on the cost of healthcare and serve only to punish the victims of medical negligence and their attorneys, the messengers who highlight the enormity of the costs of medical negligence. Barriers to the filing of medical negligence lawsuits and restrictions on the payments to those injured by proven negligence will not reduce the medical liability insurance costs and will not increase the number or availability of physicians. True reform can only be achieved by reducing the frequency of negligently-caused patient injuries.

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203. U.S. Newswire, at http://releases.usnewswire.com/GetRelease.asp?id=58720 (last visited Jan. 3, 2006) (citing study found at http://www.consumerwatchdog.org/malpractice/rp/5714.pdf (last visited Jan. 3, 2006)).

204. *Id.*

205. *Id.*

206. *Id.*