

REAL REFORM vs. TORT REFORM

**Real solutions to real problems that will save lives,
reduce costs, and serve the rights and needs
of Pennsylvania's families**

Presented to the PA House of Representatives
Judiciary Committee

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Committee for Justice for All

David I. Falk, Esquire, President
Paul Lyon, Coordinator



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“Representative government and trial by jury are the heart and lungs of liberty. Without them we have no other fortification against being ridden like horses, fleeced like sheep, worked like cattle and fed and clothed like swine and hounds.”

? John Adams, 1774



Introduction

Honorable Members of the House Judiciary Committee:

My name is Attorney David I. Fallk. I am here today with our coordinator, Paul Lyon, on behalf of The Committee for Justice for All and the people of Northeastern Pennsylvania, whose rights we promote and defend. We wish to thank you for the opportunity to address the issue of medical liability and proposals to limit the rights of injured patients and their families.

I come here today to advocate for real reform, not tort reform. Real reform addresses real issues and promotes safety. Real reform provides information that enables every patient and consumer to make better choices for his or her family. Real reform not only promotes responsibility, it holds wrongdoers accountable for their actions. In contrast, tort reform diverts attention from the benefits of real reform and results primarily in higher profits for insurance companies.

Background

More than a decade ago, the Institute of Medicine issued a shocking report, which found that medical errors were killing as many as 98,000 Americans a year. A few years later, HealthGrades, an independent evaluator of hospitals and health-care providers, issued a study finding that the annual number of malpractice deaths could be almost double the IOM figure. Consensus, however, has coalesced around the upper reaches of the IOM report. Sadly, a follow-up report last year by Consumers Union, publisher of the respected Consumer Reports magazine, found that little has been done

to implement the IOM's recommendations and that the annual death toll from medical malpractice has continued virtually unabated. By that reckoning, in the last decade or so, while political efforts have focused almost entirely on enacting various schemes to limit the legal recourse of injured patients and their families, more than a million Americans have died unnecessarily at the hands of our health-care system.

In the decade since the 1999 Institute of Medicine report, "To Err Is Human," more than 1 million Americans have lost their lives to medical malpractice.

Nevertheless, tort reformers have remained unabashed in their attempts to curtail injured patients' rights, as we have heard here today. The result of those efforts is that 46 states¹, including our own, have enacted some type of tort reform. Yet, no state that has placed its priority on tort reform has recorded a decrease in either injuries or deaths caused by malpractice. Nor has any state shown a decrease in the cost of health care resulting from tort reform.

No state that has enacted tort reform has recorded a decrease in either injuries or deaths due to malpractice, nor has any state with tort reform shown a decrease in the cost of health care.

¹ Source, American Association for Justice

Instead, as we have seen from the annual reports of the Pennsylvania Patient Safety Authority² and the Pennsylvania Supreme Court³, the number of errors and serious events resulting in injury or death in the Commonwealth's hospitals has steadily grown while the number of lawsuits has steadily dropped.

In Pennsylvania, the number of medical errors, including “serious errors” that cause injury and death, has grown every year since tracking began in 2004.

The folly of pursuing tort reform at the expense of real reform may be better illustrated by taking the issue out of the context in which we are now engaged and by looking at how other more successful programs have addressed public safety, transparency and accountability.

Let's look at drunk driving:

Just over 20 years ago, in 1989, the National Highway Transportation Safety Authority recorded 22,404 alcohol-related traffic deaths. A decade later, the number of drunk driving deaths had dropped approximately 30 percent to 15,786. Remember, that was the same year the IOM attributed 98,000 needless deaths to medical errors. The latest statistics available from NHTSA, found that in 2008 traffic deaths related to alcohol had dropped significantly again to 11,773.

² See Chart, Appendix 1

³ See Chart, Appendix 1

No doubt, the efforts of Mothers Against Drunk Driving and other groups that call attention to the problem, identify wrongdoers and demand accountability have had a salutary impact. So too has the action of government. Legislatures have lowered the blood-alcohol level needed to be declared impaired, increased penalties, and funded educational and prevention programs.

However, the courts also played a large part by enforcing the laws. Wrongdoers are not protected by secret reviews, nor are they shielded from full accountability by limitations on damages for harms done. During court proceedings, victims and their families, rather than the tortfeasors, are given community support.

Thus, here in 2010 we stand at a perch from which we can see two societal problems and two completely different approaches to addressing those problems. Each involves negligent conduct resulting in serious injuries and deaths. In the case of alcohol-impaired drivers, the death rate has been driven down to almost half of what it was two decades ago, and the trend line is clearly downward. In the case of medical malpractice, serious death and injury continues unabated, and in Pennsylvania is documented to be rising. Sadly, Americans are now more than eight times more likely to be killed by their trusted health-care provider than they are by a drunk driver.

**Medical malpractice kills eight times
as many Americans as drunk drivers.**

Nor is the drunk driving comparison a singular case. Our society rightfully regards breast cancer to be a grave concern. The death rate from that disease is just over 40,000 per year⁴, mostly women, and has remained fairly stable over the last decade. For those 40,000 or so victims, we have a large national organization – the Susan G. Komen Foundation – that promotes public awareness, coordinates fundraising to help eradicate the problem, and supports victims of the disease. There are countless walks and races for “the cure,” even though no such cure yet exists. We fund government research to find out what causes the disease and to develop and promote preventative measures.

As I stated before, medical malpractice kills some 98,000 Americans or almost two and a half times as many as die from breast cancer. Yet, there are no national organizations comparable to Komen that address or even draw attention to the ongoing toll of malpractice. There are no colored ribbons for medical malpractice awareness. And the most publicized marches on the issue are directed not at supporting victims

⁴ Source, American Cancer Society 2008

and their families but at restricting victims' or their survivors' rights. However, unlike breast cancer, malpractice is completely preventable.

**Annual malpractice deaths exceed deaths
from breast cancer, prostate cancer, drunk driving
and large truck accidents *combined*.⁵**

Prescription for Real Reform

So what should we be focusing our efforts on and what can we do to eliminate, or at least sharply reduce, the scourge of malpractice? We should take a page from what works from the wars on drunk driving and breast cancer, and we should stop following policies that have led us away from saving lives. Allow me to assert some propose some real reforms:

Provide a Presumption of Negligence for Never Events

Following the IOM report, the National Quality Forum undertook a research task to improve health care and found 28 different types of health-care events that should never occur in a health-care setting⁶. Those “never events” are defined as “preventable, serious and unambiguous.” Among the better-known are such events as wrong-site

⁵ See Chart, Appendix 2

⁶ See Chart, Appendix 3

surgery, wrong-person surgery, foreign objects left behind during surgery, medication errors resulting in death, certain stage bed sores, administration of wrong gases and infliction of burns during care.

**According to the National Quality Forum,
there are 28 types of “never events” that should never occur
in a health-care setting, including wrong-site surgery
and medication mix-ups.**

Eventually, members of the Leapfrog Group, a coalition of large employers who pay health-care benefits to their employees, decided not to reward the occurrence of some of these events by withholding payment, a move eventually followed by Medicare and the Commonwealth under Medicaid in 2007.

There is more that can be done. Since a consensus has concluded that these events should never occur, we would urge the Legislature to pass a law allowing the presumption of negligence in cases where litigation results from an occurrence of one or more of these “never events.” Such a statute would drastically decrease litigation costs, reducing the need for plaintiff’s experts and time spent by insurance company attorneys preparing frivolous defenses.

Require Informational Posting

When my wife had surgery several months ago in Scranton, as I entered the hospital there was a prominent display of the board of directors, complete with studio portraits. Not far away was a list of employees of the month, again prominently displayed. However, if I wanted to see the hospital's infection or error rate, and how the facility's performance compared to other Scranton-area hospitals, there was nothing to be found. That must change. I lived for several years in California where each restaurant had to display in its window a health department rating for all to see. Our hospitals should do the same, because our loved ones' health care is at least as important as buying a Whopper at Burger King. Let's require posting of error and infection information.

End Medical Secrecy

Many years ago, this Legislature granted the medical community the privilege of secrecy during peer review⁷, the process employed by hospitals to study circumstances surrounding medical errors. This special privilege was upheld by our courts⁸ because health-care providers promised that allowing hospitals and doctors to police their own would decrease errors and thereby lower the cost of health care. The Patient Safety Authority statistics, as produced by the hospitals themselves for much of the past decade, compel the unassailable conclusion that patient safety has not improved. Nor

⁷ 63 P.S., Sec. 425.1

⁸ *McClellan v. HMO*, 686 A.2d 801, 546 Pa. 463 (1996)

can anyone seriously argue that the costs of errors and health care have gone down. In fact, just the opposite has occurred.

There is an oft-cited maxim that when the reason for a law no longer exists, the law should no longer exist. It is time to end peer review secrecy and put the interests of harmed patients first in assigning responsibility. The records of peer review proceedings should be discoverable to patients and/or their families in any medical misadventure, regardless of whether it results in litigation. Furthermore, if peer review finds fault with a provider's actions that resulted in harm, then a heightened standard should apply to any defense put forth in order to prevent a frivolous prolonging of litigation.

Ban Secret Lawsuit Settlements

Some states and federal courts have moved in this direction and several judges in Northeastern Pennsylvania have refused to shield malpractice settlements from public scrutiny. Although not part of the law, the MCARE Fund routinely makes secrecy a condition of its agreeing to pay any part of a settlement, often delaying resolution of a case. Silencing victims so that they cannot tell their stories, or depriving patients of valuable information about health-care providers, serves no legitimate public purpose and the practice should end.

Enact Insurance Reform

The MCARE Act was passed in 2002 as a crisis mentality gripped our Commonwealth. Insurance rates were rising and doctors threatened to leave. Although the number of physicians practicing in our state has never decreased, and the insurance cycle has reversed, doctors still fear rate hikes and complain about current rates, as well. Numbers provided by our Insurance Department reveal a startling truth⁹. Since 2003, collection of premiums has well exceeded payouts for malpractice claims, and the gap has been widening. For each of the last three reporting years, premiums charged by the state's malpractice insurers have exceeded claims paid by roughly \$350 million or more. Additionally, those insurance carriers have garnered untold returns on investing the hundreds of millions of dollars they have collected and held in reserve.

Since 2003, collection of premiums has far exceeded payouts for malpractice claims, and the gap has been widening.

The new national Health Care Reform Act passed in March compels health-care insurers to pay out at least 80 percent of premiums toward benefits, rather than enriching executives. Given the payout-to-collections ratios that exist in Pennsylvania, a similar requirement should be imposed on malpractice insurers. To the extent that the

⁹ See Chart, Appendix 4

amount in claims paid falls below a certain percentage of premiums collected, the difference should be rebated to doctors and hospitals. Allowing insurers to keep say, 10 percent, of the premium-payout surplus, plus all of their investment income, does not seem unreasonable. It would discourage waste and reward better-run companies, while giving much needed relief to health-care providers.

Rebalance the Scales of Justice

The MCARE Act contains certain one-sided provisions. For instance, a judge is allowed to lower the amount of verdict if deemed excessive (remittitur), but he or she may not raise a clearly inadequate verdict (additur) without ordering a new and costly trial. The judiciary should be given the power of additur.

The Act also calls for certification by a plaintiff of procurement of an opinion that the standard of care has been breached. An extensive study published in the New England Journal of Medicine in 2006¹⁰ indicates that far more meritorious cases are lost than non-meritorious cases won. Therefore, the certification requirement should also be imposed upon a defendant who wishes to deny liability – a defense certificate of merit.

The Act allows for payment of full economic damages, but the victim often loses some or all of those parts of the verdict to subrogation by health insurers. In essence, the health insurer gets a free ride and risks nothing to recover its full loss. This is unfair. Also, sometimes the health insurer refuses to adjust its subrogation interest, thus frustrating settlements. A victim who recovers a malpractice verdict should get

¹⁰ “Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,” New England Journal of Medicine, Vol. 354:2024-2033, May 11, 2006

credit in subrogation for the full value of premiums paid to the health insurer. If an insurer's refusal to sufficiently adjust a lien results in a trial and a verdict lower than the offer, the health insurer should bear the full cost of its refusal to compromise.

Conclusion

As I stated when I began, real reform is not only necessary, it is long overdue. Each year in our Commonwealth, more than 8,600 men, women and children are either seriously harmed or killed by health care delivered in hospitals – and that number is probably low because there is widespread underreporting by the state's hospitals. It also does not include errors committed in nursing homes, private practices or other health-care settings. Be that as it may, the number of patients harmed by serious errors in Pennsylvania in 2008 was more than the combined populations of the Borough of Clarks Summit (5,126) where I live, and Newton Township (2,699) where my children go to school.

In 2008, medical malpractice injured or killed the equivalent of the populations of Lower Swatara Twp. (8,149), Collingdale (8,664), Ellwood City (8,688) or Latrobe (8,994).

And it is all preventable, so long as we stay focused on the real problem. Tort reform is not a solution. It has focused on patients and their rights only to impose

restrictions. Real reform will empower our Commonwealth's families through knowledge. Real reform will promote and reward safety first and justly impose accountability. And it will lower physician costs. Moreover, real reform is the moral and right thing to do. Thank you.

Real Reform Checklist

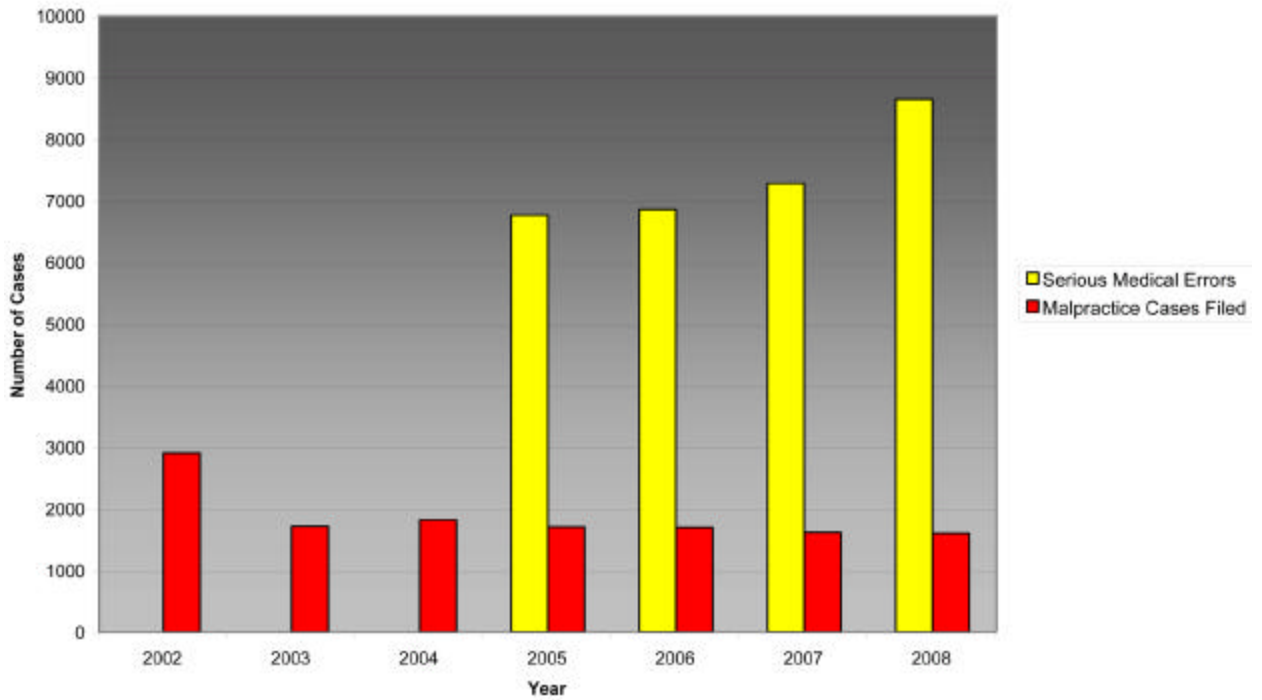
- Lower the incidence of malpractice
- Presume “never events” to be negligent
- Give patients more and better information
- Post error and infection rates in hospitals and online
- End secret self-policing by health-care providers
- Ban secret settlements in lawsuits
- Limit insurance company gouging and rebate surpluses
- Allow additur to increase inadequate verdicts
- Require certificates of merit for the defense
- Limit subrogation

APPENDICES

Appendix 1

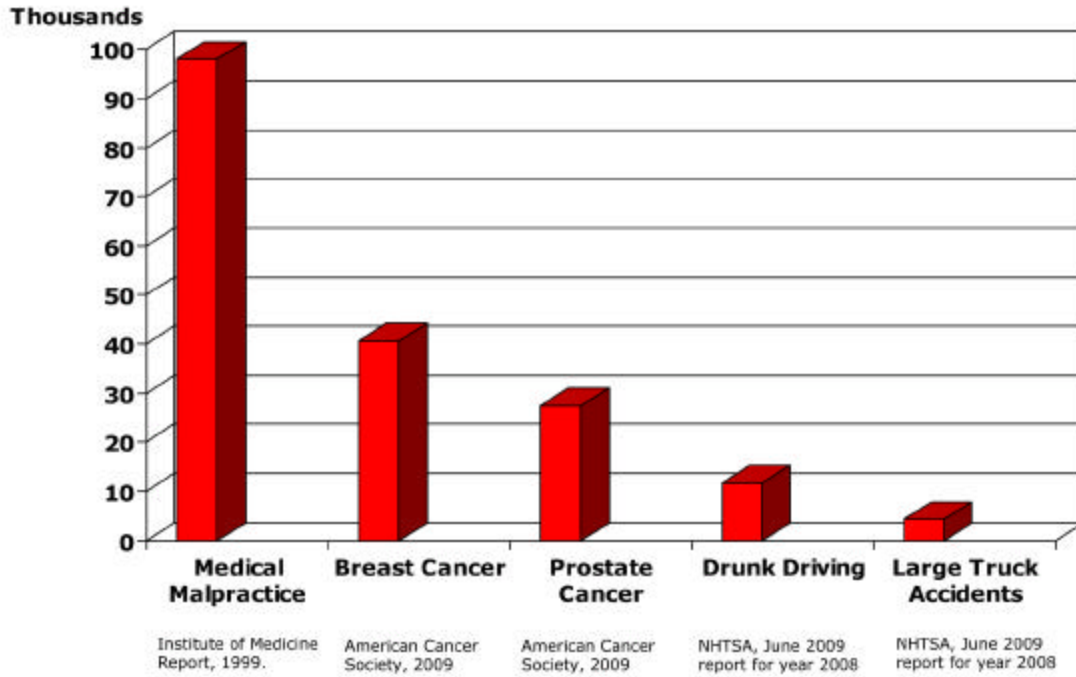
Serious Medical Errors vs. Malpractice Lawsuits

Sources: PA Patient Safety Authority Annual Reports, 2004-2008
Administrative Office of the PA Courts - PA Medical Malpractice Case Filings: 2000-2008



Appendix 2

Annual Causes of Death: United States



Appendix 3

Medical “Never Events”

Compiled by the National Quality Forum (2006)

Surgical events

- 1) Surgery performed on the wrong body part
- 2) Surgery performed on the wrong patient
- 3) Wrong surgical procedure performed on a patient
- 4) Unintended retention of a foreign object in a patient after surgery or other procedure
- 5) Intraoperative or immediately postoperative death in an American Society of Anesthesiologists Class I patient
- 6) Artificial insemination with the wrong sperm or donor egg

Product or device events

- 7) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility
- 8) Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used for functions other than as intended
- 9) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility

Patient protection events

- 10) Infant discharged to the wrong person
- 11) Patient death or serious disability associated with patient elopement (disappearance)
- 12) Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a health care facility

Care management events

- 13) Patient death or serious disability associated with a medication error (eg, errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- 14) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
- 15) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility
- 16) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility
- 17) Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates

- 18) Stage 3 or 4 pressure ulcers acquired after admission to a health care facility
- 19) Patient death or serious disability due to spinal manipulative therapy

Environmental events

- 20) Patient death or serious disability associated with an electric shock or electrical cardioversion while being cared for in a health care facility
- 21) Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- 22) Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility
- 23) Patient death or serious disability associated with a fall while being cared for in a health care facility
- 24) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility

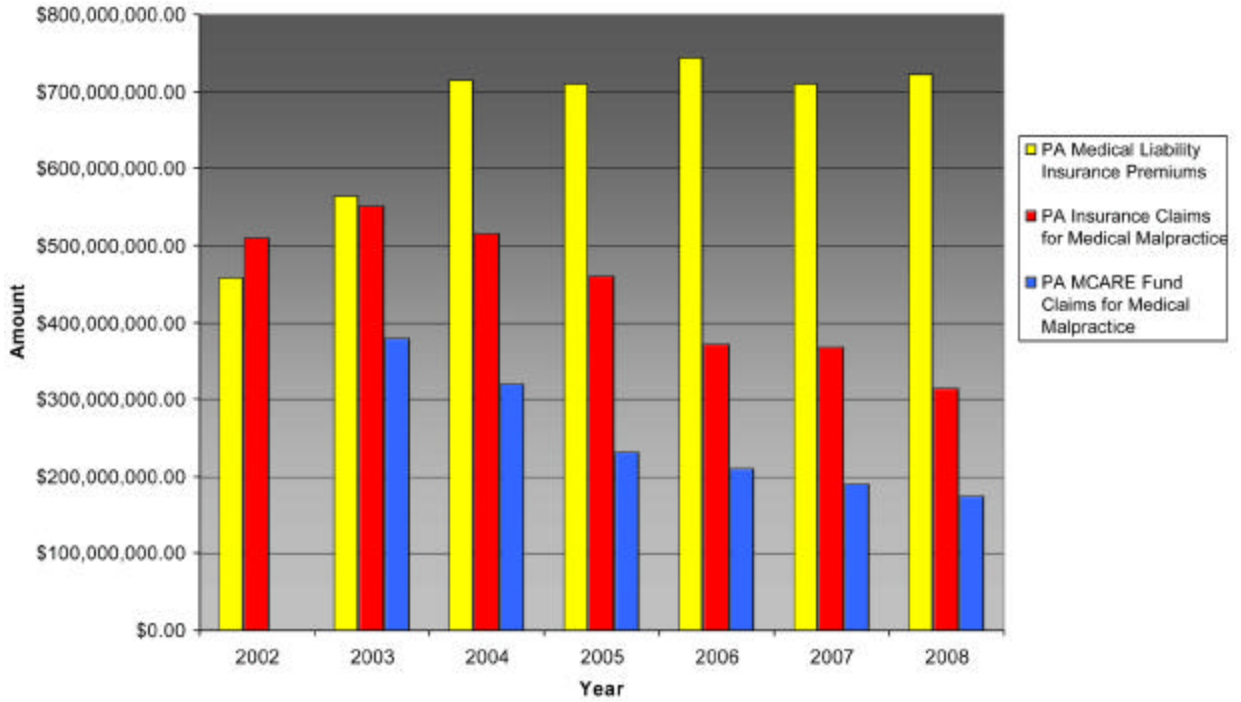
Criminal events

- 25) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider
- 26) Abduction of a patient of any age
- 27) Sexual assault on a patient within or on the grounds of the health care facility
- 28) Death or significant injury of a patient or staff member resulting from a physical assault (ie. battery) that occurs within or on the grounds of the health care facility

Appendix 4

Medical Malpractice Claims vs. Insurance Premiums

Source: Annual Statistical Report of the Insurance Department of Pennsylvania, 2002-2007



Appendix 5



PA Medical Malpractice Data: Statistics Paint a Different Picture

Year	Total Medical Errors ⁱ	“Serious” Medical Errors ⁱⁱ	Lawsuits ⁱⁱⁱ Filed	MCARE Claims Paid ^{iv}	Commercial Insurance Claims Paid ^v	Commercial Insurance Premiums Earned ^{vi}
2000	N/A	N/A	2,632	N/A		
2001	N/A	N/A	2,659	N/A		
2002	N/A	N/A	2,904	N/A	\$510,741,000 (FY02-03)	\$458,131,000 (FY02-03)
2003	N/A	N/A	1,712	\$378,720,772	\$551,557,000 (FY03-04)	\$564,017,000 (FY03-04)
2004	70,851	N/A	1,817	\$320,339,689	\$515,800,000 (FY04-05)	\$716,373,000 (FY04-05)
2005	169,072	6,763	1,700	\$232,588,740	\$460,733,000 (FY05-06)	\$710,923,000 (FY05-06)
2006	195,832	6,854	1,693	\$209,522,349	\$372,480,000 (FY06-07)	\$745,104,000 (FY06-07)
2007	211,983	7,277	1,617	\$191,365,811	\$369,151,000 (FY07-08)	\$709,922,000 (FY07-08)
2008	219,874	8,645	1,602	\$173,892,874	\$315,145,000 (FY08-09)	\$722,274,000 (FY08-09)

ⁱ PA Patient Safety Authority Annual Reports, 2004-2008

ⁱⁱ PA Patient Safety Authority Annual Reports, 2004-2008

ⁱⁱⁱ “PA Medical Malpractice Case Filings: 2000-2008,” Administrative Office of the PA Courts, April 2009

^{iv} “MCARE Fund Annual Report of Operations,” 2003-2008

^v “Annual Statistical Reports of the Insurance Department of Pennsylvania,” 2002-2009

^{vi} “Annual Statistical Report of the Insurance Department of Pennsylvania,” 2002-2009