

# ***The Truth about Torts: An Insurance Crisis, Not a Lawsuit Crisis***

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## ***Introduction***

President Bush has made changing the civil justice system a priority for his second term, asserting that federal displacement and adjustment of traditional state tort law is necessary both to respond to the nation's healthcare crisis and to bolster its economy.<sup>1</sup> The issues raised by so-called "tort reform" proposals are far-reaching and important. Certainly careful analysis should precede an effort to alter radically the common law of torts, which represents more than six centuries of accumulated wisdom among judges, citizen-jurors, and litigants about how best to hold defendants accountable for wrongful conduct and to secure justice for injured victims. But upon careful review, we find that much of the debate over the civil justice system is plagued by unfounded claims, shrill rhetoric, and mythical anecdote.

In the "Truth about Torts" series of white papers, CPR undertakes a more careful, systematic examination of the torts issue, beginning with medical malpractice liability, which the Bush administration has placed at the top of its tort-restriction agenda. Our aim throughout will be to highlight significant empirical and theoretical knowledge about the tort system, information that is oddly ignored in relevant policy debates. We also aim to place that knowledge in the broader legal context of how society can reliably identify and manage risks of harm to life and limb. The push for tort "reform" has debased the conversation about the tort system in many ways, but the most harmful and distracting way may be the general failure to appreciate how tort law relates to other legal and non-legal systems for preventing, compensating, and deterring death and injury. Because proponents of tort "reform" generally fail to perceive, or at least refuse to acknowledge, the role that tort law plays in this broader context, they also deny that restricting the availability of traditional tort remedies may lead to higher levels of personal injury or may necessitate the creation of new regulatory efforts to combat such injury. A vote in favor of broad-sweeping federal legislation, in other words, may force lawmakers to face a subsequent choice between bigger government and more premature death.

## ***Executive Summary***

The United States is suffering both from a healthcare crisis, one of the symptoms of which is an unnecessarily high number of malpractice injuries, and from an insurance crisis. There is, however, no tort lawsuit crisis—in medical malpractice liability or otherwise. The insurance industry, managed-care companies, and organizations representing healthcare providers have invested a great amount of money in political contributions and media campaigns to convince policy-makers and the public that the civil justice system is fraught with meritless claims and is consequently the cause of the recent increase in malpractice premiums. But a mounting number of studies are finding that the tort system in general and malpractice liability in particular have been quite stable for the past two decades. And examinations of insurance industry practices reveal insurers' business decisions as the source of premium volatility—not the amounts insurers are paying out on malpractice claims. More specifically, the recent premium spikes were insurance companies' attempt to make up for losses that they incurred as a result of offering artificially low premiums to increase their market share and depending instead on projected income from risky investments to meet future payout obligations.

In addition to shifting the blame for skyrocketing malpractice premiums from insurance companies to the civil justice system, corporate interests and the politicians they support have shifted the blame for the alarming lack of access to affordable, quality healthcare from the for-profit entities that run the U.S. healthcare system to malpractice victims and their attorneys. More specifically, advocates of restrictions on medical malpractice liability claim that rampant lawsuit "abuse" is driving physicians to practice so-called defensive medicine and to leave the medical field, both of which increase healthcare costs and diminish healthcare availability. Given the overwhelming evidence of stability in the civil justice system, it is not surprising that neither the defensive-medicine claim nor the physician-flight claim withstand empirical scrutiny. The Bush administration's primary support for the claim that doctors are ordering unnecessary tests and procedures out

of fear of being sued is a study that two non-partisan congressional research agencies have dismissed as unreliable because it projects extremely limited findings onto the entire nation. More appropriately-designed studies have found little or no evidence that fear of liability results in unnecessary medical expenditures. And regarding the supposed physician flight, the Government Accountability Office recently reported that the physician supply in this country has been increasing faster than the population for the past decade.

In short, the administration, other tort-“reform” politicians, and big businesses have fabricated a “lawsuit” crisis to defraud the American people of their right to redress for wrongful injury and their ability to hold the perpetrators—no matter how wealthy and powerful—accountable in the civil justice system. Information readily available to the administration and federal legislators promoting tort “reform” makes clear that the civil justice system is not inundated with baseless claims, that insurance companies’ losses in malpractice lawsuits are not driving premium hikes, that doctors are not disappearing, and that there is no surge in “defensive medicine” responsible for increased healthcare costs. Thus, the restrictions on medical malpractice liability that President Bush insists Congress must enact serve only to provide immunity (1) for healthcare providers who commit malpractice by denying victims access to the courts, and (2) for insurance companies, who raised premiums to recover from losses incurred as a result of their own imprudent business practices and who now seek to evade responsibility for this imprudence and to maximize future profits by blaming malpractice victims for the premium hikes. Furthermore, the healthcare crisis will continue as long as the nation’s focus remains fixed on a chimerical cause of that crisis—i.e., the civil justice system—instead of the real causes—i.e., the insurance, managed-care, and pharmaceutical industries that largely control healthcare delivery in the United States. Addressing the healthcare crisis requires ensuring everyone access to quality healthcare, which, in turn, requires reining in these corporations, not immunizing them from citizens’ check on the public health risks posed by their profit-maximizing behavior.

### **Background: Corporate Immunity in the Guise of Tort ‘Reform’**

A “tort” is a harm to a person caused by the wrongful conduct of another. Tort law is the set of legal principles that courts have developed over time to provide compensation and vindication to victims, to punish responsible parties for their misconduct, and to prevent

others from being similarly harmed in the future by holding responsible parties accountable. These principles originally developed out of longstanding Anglo-American prohibitions against battery and trespass: physical invasions of an individual’s person or property by another individual. New types of harm and different sorts of harmful actors emerged with the industrialization of society, forcing courts to adjust tort law over time to fit the new social and economic conditions.<sup>2</sup> For instance, given the vast system of economic intermediaries that had developed in between consumers and the primary designers and developers of modern products after World War II, common-law courts began adjusting tort doctrines to allow consumers to sue manufacturers directly for product-caused injuries. Not long thereafter, big businesses, including the insurance, manufacturing, oil and gas, and chemical industries, began decrying the civil justice system as a source of unfair, unpredictable, and economically disastrous tort awards.<sup>3</sup>

The resulting decades-long policy debate has been vociferous, and for an understandable reason: The key ways in which these business interests have sought to change the tort system also appear to be the key ways in which the system empowers individual people to protect themselves and their fellow citizens against corporate wrongdoing. They include:

- the right of plaintiffs to appear before a jury of their fellow citizens, and the right of those citizens to participate in governance as part of the civil justice system, which supplements and backs up the legislative and executive branches as society’s “quality-control guardian of products and services”<sup>4</sup>;
- the civil procedure discovery system, which allows ordinary citizens in litigation to compel corporations to produce important information previously kept hidden from the public;
- non-economic compensatory damages, which in practice have worked to ensure that society’s most vulnerable members—including the poor, minorities, the elderly, and children—are not deprived of full compensation for catastrophic injuries because of their low or non-existent income, and that the pain and suffering of victims living with the worst injuries are not discounted because they escape precise quantification; and
- punitive damages, which allow citizen-jurors to punish egregious disregard of human life and health in the quest to maximize the bottom line.

Corporate entities have accompanied their call for changes in the civil justice system with a consistent message that the system is chaotic, unpredictable, and easily manipulated by shady trial lawyers who have perfected the art of convincing juries to issue immense damage awards based on emotion rather than on legal standards. As detailed in this white paper series, neither this claim nor its corollary—that the supposed “out of control” system endangers healthcare and the economy in this country—are borne out by the evidence. Moreover, changes advocated by the Bush administration and other proponents of “tort reform” would impair the civil jury’s long-standing power to hold actors accountable for the consequences of risk-producing products and activities in appropriate cases. As we will explain, this flexible role provides a particularly important complement to executive and legislative branches of government, which often are incapable of addressing the full range of potentially harmful products and activities because of limited time and foresight, and because their agendas are influenced by powerful interests in ways that may not best represent the public interest. Put together, the lack of evidence supporting the claims of big business regarding a tort system in chaos, coupled with the hidden but significant deregulatory benefits that those interests stand to gain from altering traditional common law liability rules, suggests that “tort reform” is an inapt description and that *corporate immunity* better captures the effect of current proposals.<sup>5</sup>

## **The Truth About Medical Malpractice: An Insurance Crisis, Not a Lawsuit Crisis**

During his first presidential outing in 2005, President Bush launched an aggressive campaign for a national overhaul of medical malpractice liability,<sup>6</sup> pressing Congress to enact legislation restricting liability not only for healthcare providers, but also for companies that produce drugs and other medical products.<sup>7</sup> Similar legislation has been adopted in several states,<sup>8</sup> and the U.S. House of Representatives has passed malpractice liability bills a number of times in the past.<sup>9</sup> To date, however, there has been sufficient opposition in the Senate to prevent malpractice legislation from being enacted at the federal level.<sup>10</sup> President Bush and his backers believe that this year may be different: In calling on Congress “to pass real medical liability reform this year,” Bush asserted that “he had often talked about

malpractice liability in last year’s campaign, and [thus] he now had a mandate.”<sup>11</sup>

Medical malpractice bills currently in committee in both the House and the Senate<sup>12</sup> limit liability for healthcare providers and manufacturers of medical products by, *inter alia*, capping non-economic compensatory damages (known as “pain and suffering” damages) at \$250,000,<sup>13</sup> restricting the availability and amount of punitive damages,<sup>14</sup> requiring plaintiffs to bring claims within three years of manifestation of their injury,<sup>15</sup> and restricting the amounts attorneys may collect on a contingency fee basis.<sup>16</sup> Although these bills contain empty gestures toward the “protection of states’ rights,” in truth they constitute an extraordinary encroachment upon states’ longstanding authority to promulgate tort laws and regulate the legal profession within their borders. Nevertheless, according to President Bush, such legislation is necessary because the filing of “baseless lawsuits” “all across this country” has resulted in increasingly high insurance premiums, in the practice of “defensive medicine” by doctors, and in a flight of doctors from the medical profession.<sup>17</sup>

It is certainly true that the United States faces a healthcare crisis: more people in this country die each year from preventable medical errors than from motor vehicle accidents. More alarmingly, the number of people in this country who cannot afford basic healthcare stands in the tens of millions and has increased steadily over the past decade, including a large portion of uninsured Americans who are working one or more jobs. There is also an insurance crisis of sorts: malpractice insurers sharply increased premiums around the turn of this century, as they have in several previous insurance crisis episodes. A review of the evidence, however, suggests that there is no lawsuit crisis—an almost unbelievable conclusion given the steady rhetoric of the tort “reform” debate, but one that is supported by a wealth of underappreciated data and careful analysis of the civil justice system. More importantly, the misleading claims about the causes of serious problems in the insurance industry and the healthcare system serve to distract the public and its policymakers from the kind of measures that would more clearly benefit society—i.e., insurance reform and healthcare reform.

### **I. There is a malpractice crisis.**

Like any business or profession, healthcare providers make mistakes. Indeed, according to the National Academy of Science’s Institute of Medicine (“IOM”), “medical errors are the leading cause of accidental death in the United States.”<sup>18</sup> IOM estimates that “[a]t least 44,000

people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented.”<sup>19</sup> Moreover, IOM cautions that these numbers are a “very modest estimate of the magnitude of the problem since hospital patients represent only a small proportion of the total population at risk from medical errors.”<sup>20</sup>

One might think that this apparently widespread problem of medical error would help to explain the claim—repeatedly made by proponents of federal control over the state civil justice system—that courts are being flooded by tort suits. However, as the Congressional Budget Office recently pointed out, “the evidence suggests that very few medical injuries ever become the subject of a tort claim.”<sup>21</sup> Indeed, the medical malpractice liability system appears to be greatly underutilized by those with meritorious claims. For example, data compiled in the landmark Harvard Medical Practice Study, which remains the most important attempt to document the extent of medical negligence in the healthcare system, indicated that the tort system was vastly underutilized. Specifically, although the researchers found that there were 27,179 cases of medical negligence in New York State hospitals in 1984—representing nearly one percent of hospital admissions and an even greater percentage of admissions for serious injuries—they also found that only 1.5 percent of these victims filed medical malpractice claims.<sup>22</sup> Even for medical malpractice claims that are brought to court, the population-adjusted number of claims filed in the states reporting to the National Center for State Courts dropped by 1 percent from 1992 to 2001.<sup>23</sup>

Although the evidence indicates that few malpractice victims seek redress in the civil justice system, it is currently a principal means by which healthcare providers are held accountable for medical error. There is no national system for disciplining medical practitioners; instead, oversight is left to state medical boards whose members are mostly physicians and whose disciplinary practices have been inadequate.<sup>24</sup> For instance, although very few doctors appear to be responsible for most of the malpractice in this country—a mere 5 percent committed over half of the malpractice that occurred from 1990 to 2002<sup>25</sup>—physicians as a group tend to be reluctant to revoke licenses or to take other disciplinary action that would protect future patients from medical negligence by this small percentage of practicing doctors.<sup>26</sup> State medical boards disciplined only 8 percent of the 35,000 doctors who made two or more payments on malpractice claims from 1990 to 2002 and only 17 percent of the 2,744 doctors

who made five or more malpractice payments during that time period.<sup>27</sup>

In light of these figures, it is not surprising that a recent *Washington Post* review of state medical board records found that “[s]cores of physicians in [the District of Columbia, Virginia, and Maryland] and across the country have been given repeated chances to practice, despite well-documented drug and alcohol problems.”<sup>28</sup> According to the *Post*, records show that these doctors “have stayed in business with the permission of state medical boards and hospitals, even when many have relapsed multiple times and posed a danger to patients.”<sup>29</sup> Furthermore, because of weaknesses in the national system for reporting of state disciplinary actions, even the relatively few physicians whose licenses are revoked by medical boards are often able to obtain licenses in other states and commit malpractice again. Congress created a national reporting system, known as the National Practitioner Data Bank (“NPDB”), “to allow licensing boards and employers to check on doctors’ records before they are hired and to prevent problem doctors from state-hopping.”<sup>30</sup> Nevertheless, the NPDB is woefully incomplete because many doctors subject to disciplinary action are either never reported or are reported so late that they are able to move and set up practice elsewhere.<sup>31</sup>

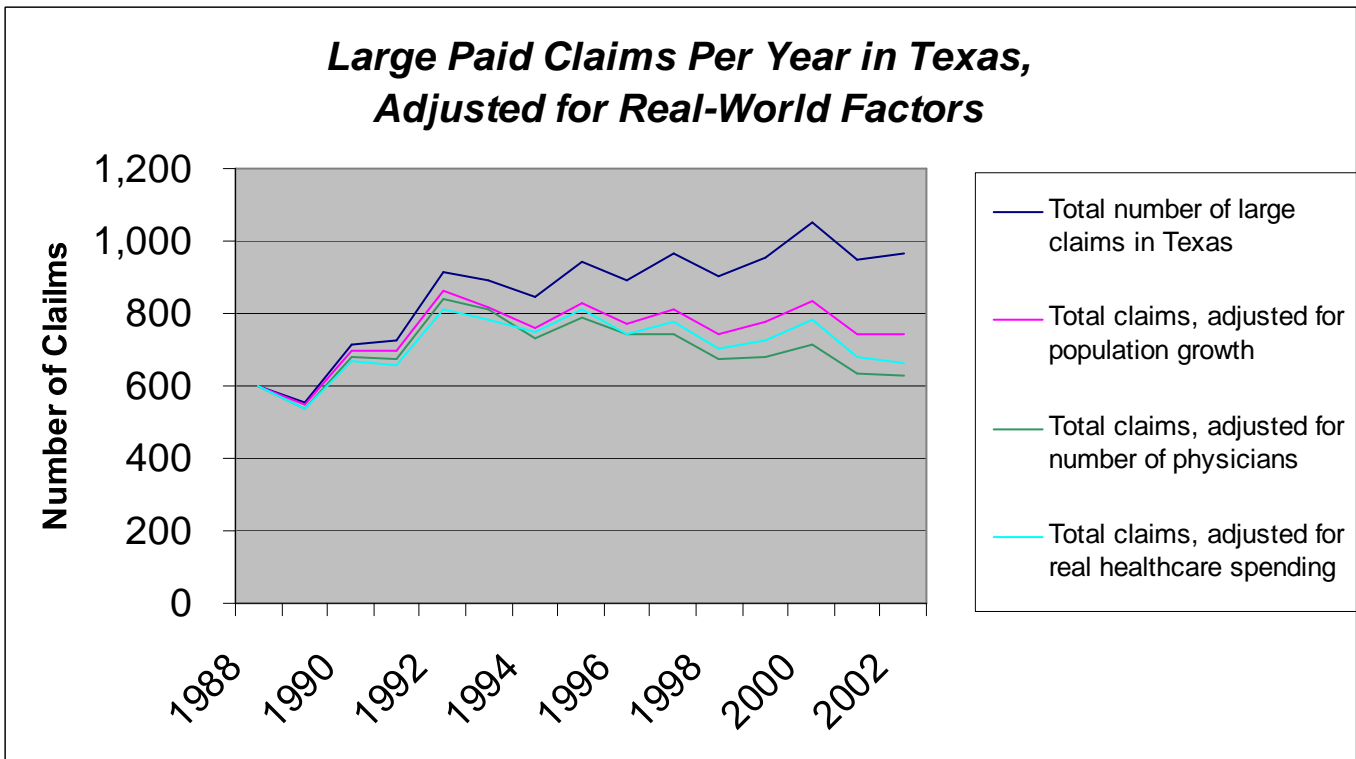
In light of such findings, Sidney Wolfe, a physician who is director of Public Citizen’s Health Research group, wrote in a *New York Times* opinion article that the country is suffering from “an epidemic of medical errors.”<sup>32</sup> He further noted that “[i]f medical boards, which are state agencies, are unwilling to seriously discipline doctors who repeatedly pay for malpractice—including revoking medical licenses from the worst offenders—then legislatures must step in and change the way the boards operate.”<sup>33</sup> Until government leaders adopt some serious measures to combat medical error along these lines, the civil justice system will remain both the primary recourse for injured victims and the primary means of deterring future misconduct.

## **II. There is an insurance crisis.**

From the late 1990s to around 2002, property and casualty insurance companies dramatically increased premiums for many of their policyholders, including those seeking coverage for medical malpractice liability.<sup>34</sup> For example, in Texas, one of the states that the American Medical Association (“AMA”) recently declared to be in a “medical liability crisis,” malpractice premiums rose 135 percent from 1999 to 2002.<sup>35</sup> Advocates of removing or

restricting access to civil justice for victims of medical injury point to such figures as evidence that their policy proposals are needed. They ignore some inconvenient aspects of the story, however. For instance, in 1995 the Texas legislature passed legislation—at the urging of then-Governor George W. Bush—that limited both the amount that victims could recover for their injuries and the amount of punitive damages that juries could assess for particularly egregious conduct on the part of the defendant.<sup>36</sup> When premiums continued to rise even after these legislative changes, the insurance and medical industries accused Texas residents and trial lawyers of forcing the premium hike through rampant abuse of the civil justice system and demanded even further cutbacks on the amount that malpractice victims could recover for non-economic compensatory damages—commonly known as damages for “pain and suffering.”<sup>37</sup>

The fact that insurance companies increased premiums notwithstanding the 1995 Texas legislation in itself renders suspect the industry’s attribution of blame to the civil justice system. A recent study of medical malpractice claims in the state leaves no doubt that, as University of Illinois Professor David Hyman, put it, “at least in Texas, the tort system can’t be the cause of spikes in malpractice premiums.”<sup>38</sup> In a *New York Times* editorial describing their findings, the authors—three law professors and one professor of law and medicine—stated that, “[a]fter studying a database maintained by the Texas Department of Insurance that contains all insured malpractice claims resolved between 1988 and 2002, we saw no evidence of a tort crisis.”<sup>39</sup> Instead, the researchers found that, “as far as medical malpractice cases are concerned, for 15 years the Texas tort system has been remarkably stable.”<sup>40</sup> According to several different measures—such as the number of large claims, the number of total paid claims adjusted for physician growth and population, the mean and median

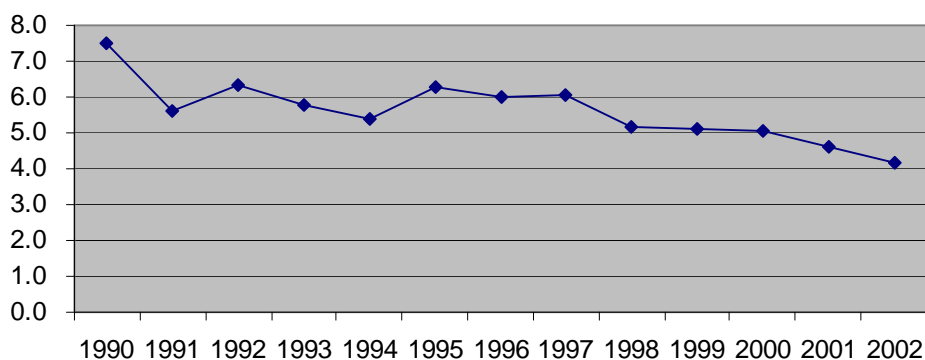


Number of non-duplicate large paid medical malpractice claims per year from 1988-2002 for the researchers’ “broad” dataset, adjusted for Texas population, total real Texas healthcare spending (adjusted for general inflation but not for healthcare inflation), and Texas physicians. The broad (“BRD”) dataset includes all reports submitted to the Texas Department of Insurance on closed large medical malpractice claims that were coded as covered by medical professional liability insurance policies, as against healthcare providers, or as involving “injuries caused by complications or misadventures of medical or surgical care.” Number of claims for 1988 and 1989 is lower than the actual number due to incomplete reporting. Chart based on Figure 3 in the report on the Texas study, (cited in note 41), and underlying data provided by Professor Bernard Black.

payouts per large claim, and the total cost of large malpractice claims—the costs incurred by insurance companies as a result of malpractice claims remained constant or even declined over the purported “crisis” period that the insurance industry claimed had led to premium increases.<sup>41</sup>

This story is not unique to Texas. Florida’s legislature severely curtailed victims’ rights to recovery in 1986 to combat a supposed insurance crisis brought on by the tort system.<sup>42</sup> Despite this legislation, insurance companies have increased medical malpractice premiums in the state by “an average of 30 percent to 50 percent since 2000.”<sup>43</sup> Indeed, even after convincing Florida lawmakers to limit further medical malpractice victims’ rights to compensation in 2003, insurance companies successfully sought permission from the state insurance agency to increase rates by as much as 45 percent.<sup>44</sup> The explanation for these curious developments is not to be found in some explosion of medical malpractice suits. A study of Florida claims similar to the Texas study found that the medical

### Paid Claims per 100 Physicians in Texas

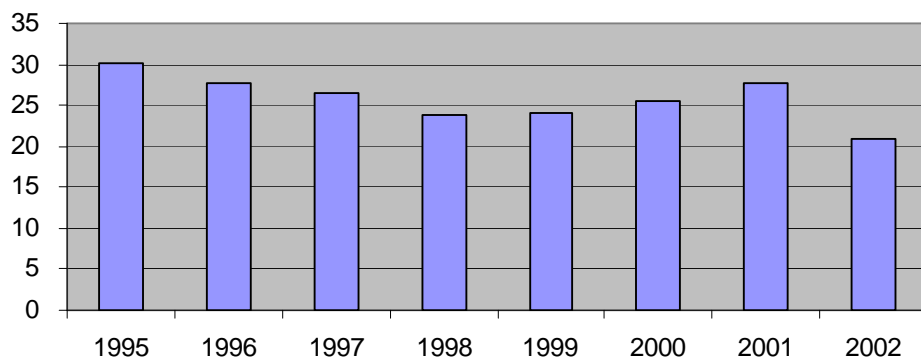


Total paid medical malpractice claims per 100 physicians per year from 1990-2002, including duplicate claims, for the researchers’ medium-sized dataset. The medium-sized (“MED”) dataset includes all reports submitted to the Texas Department of Insurance on closed medical malpractice claims that were coded as covered by medical professional liability insurance policies. Chart based on Figure 14 in the report on the Texas study, (cited in note 41), and underlying data provided by Professor Bernard Black.

malpractice liability system in Florida was essentially stable during the 14-year period from 1990 to 2003.<sup>45</sup> In particular, the researchers found that insurance companies in Florida paid approximately the same average number of malpractice claims per capita from 1999 to 2003 as they did from 1990 to 1994.<sup>46</sup> Although number of claims

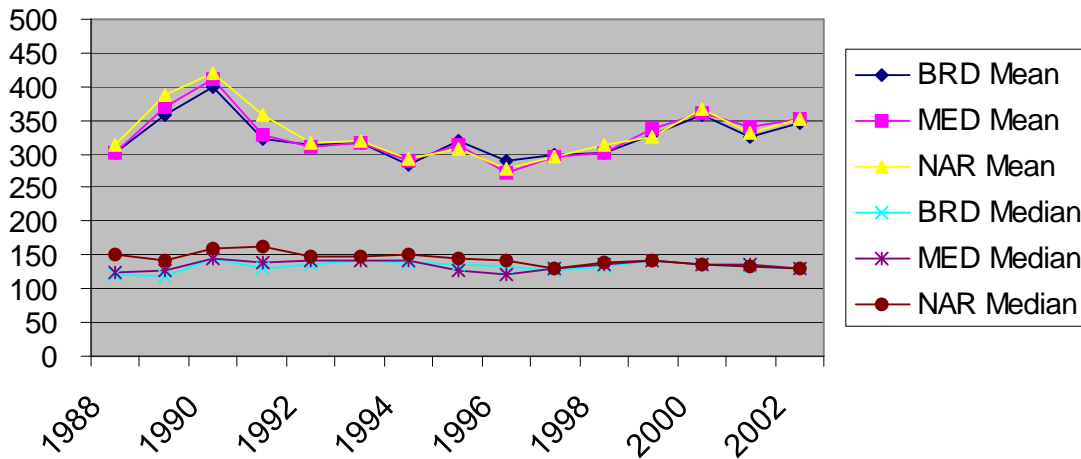
over the time period was quite stable, the researchers did observe an upward trend in mean and median recovery.<sup>47</sup> The researchers attributed this trend in large part to a change in the mix of cases reported toward more severe injuries and death, as well as possibly to increases in medical care costs that have outpaced inflation.<sup>48</sup> A particularly revealing finding is that almost 93 percent of awards for \$1 million or more, which account for a significant portion of the increase in average recovery, came from privately settled cases, rather than jury trials.<sup>49</sup> Although insurance companies claim that the threat of jury verdicts casts a “shadow” over their settlement practices, this is a hard claim to sustain when the

### Total Claims per 100 Physicians in Texas



Total medical malpractice claims per 100 physicians per year from 1995-2002, including duplicate claims, for the MED dataset. Chart based on Figure 13 in the report on the Texas study, (cited in note 41), and underlying data provided by Professor Bernard Black.

### Median and Mean Payout per Large Paid Claim in Texas



Mean and median payout in thousands of 1988 dollars per nonduplicate large paid medical malpractice claim from 1988-2002, for the BRD, MED, and “narrow” datasets. The narrow (“NAR”) dataset includes all reports submitted to the Texas Department of Insurance on closed large medical malpractice claims that bore all three codes—i.e., covered by medical professional liability insurance policies, against healthcare providers, and involving “injuries caused by complications or misadventures of medical or surgical care.” Chart based on Figure 6 in the report on the Texas study, (cited in note 41), and underlying data provided by Professor Bernard Black.

decrease in payments for medical malpractice claims.<sup>53</sup> Remarkably on the confluence of his findings with those of Texas and Florida studies, Baker said that “[w]hen we’re getting the same answer using completely different research methods, you can be pretty sure we’re right.”<sup>54</sup> Consequently, he noted that “[i]f what you want to do is protect doctors from the next malpractice insurance crisis, tort reform is not going to do it.”<sup>55</sup>

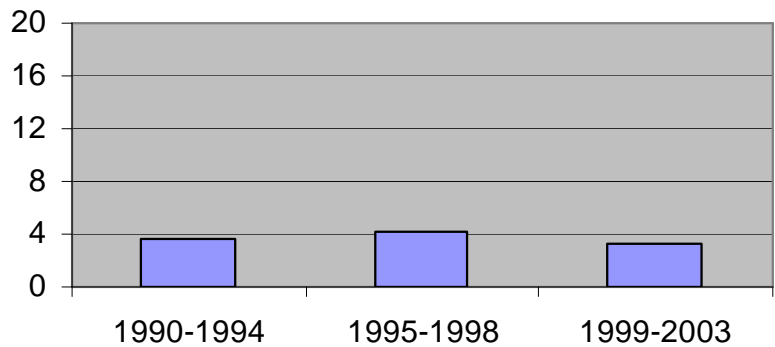
The recent malpractice insurance crisis is not

overwhelming share of large recoveries is not imposed by juries but voluntarily agreed to by insurers.<sup>50</sup> As the researchers conclude, at a minimum, their findings suggest that “debate about the role of juries in so-called ‘mega awards’ is misplaced insofar as Florida is concerned.”<sup>51</sup>

A nationwide study of the insurance business that included an examination of the amounts that insurance companies are paying for malpractice claims casts even further doubt on the claim that premium hikes have been necessitated by an “out of control” malpractice liability system. University of Connecticut Professor Tom Baker, an expert in insurance law, determined that the recent premium spike was not driven by changes in the amounts insurance companies are paying out for medical malpractice claims.<sup>52</sup> In fact, according to the Department of Health and Human Services, last year saw an 8.9 percent

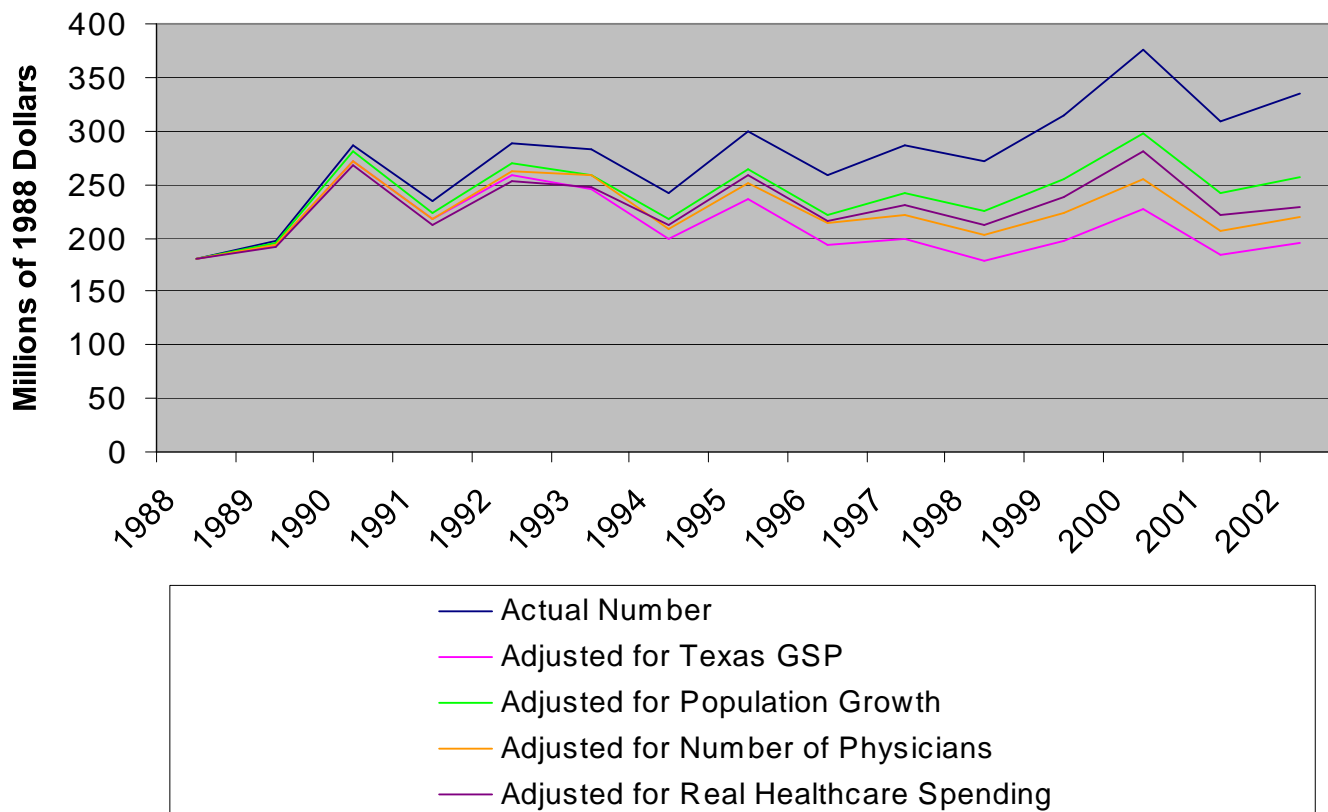
the first one that this country has experienced: similar crises

### Mean Claims per 100 Physicians in Florida



Mean claims per 100 physicians for 1990-94, 1995-98, and 1999-2003, as found by the Florida study cited in note 45.

## Total Payouts per Year for BRD Claims in Texas (1988 Dollars)



Total payouts on all large paid medical malpractice claims from 1988-2002 for the BRD dataset, adjusted for population growth, number of physicians, Texas Gross State Product (“GSP”), and Texas real healthcare spending. Payouts for 1988 and 1989 are lower than the actual amounts due to incomplete reporting. Chart based on Figure 7 in the report on the Texas study, (cited in note 41), and underlying data provided by Professor Bernard Black.

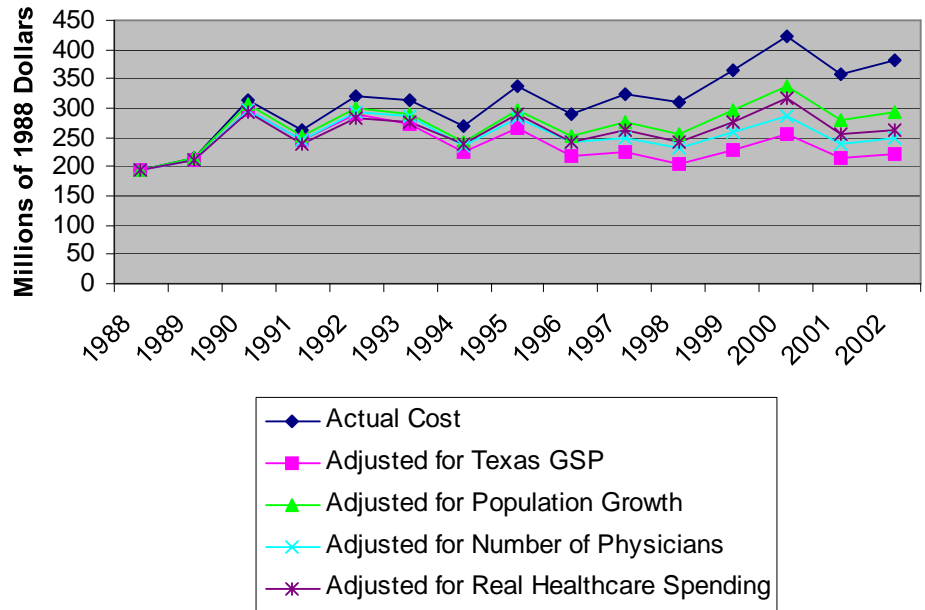
erupted in the mid-1970s and again in the mid-1980s. Like the current crisis, both of these previous episodes occurred during a time of relative stability in medical malpractice litigation and claim payments, yet both also were seized upon by the insurance industry, medical establishment, and other interests in their urgent call for limiting victims’ rights within the civil justice system.<sup>56</sup> In an attempt to address the first such crisis, California in 1975 passed the Medical Injury Compensation Reform Act (“MICRA”), which provides the model for federal legislation that President Bush is urging Congress to pass this year.<sup>57</sup> In support of a \$250,000 federal cap on non-economic damages, Bush pointed to a similar cap in MICRA and noted that “since 1975, insurance premiums for California doctors have become much more affordable than anywhere else in the

country—than in most states.”<sup>58</sup> What President Bush left unsaid, however, is the most important part of California’s malpractice-premium story: premiums in California continued to increase long after passage of MICRA, and it was not until 1988, when Californians voted in favor of “the nation’s most stringent reform of the insurance industry’s rates and practices,” that premium prices stabilized.<sup>59</sup> One of the key aspects of California’s insurance reform legislation is the requirement that insurance companies obtain the state insurance department’s approval before changing premium rates, which empowers state regulators to provide policyholders with significant protection against insurers’ imprudent financial decisions.<sup>60</sup>



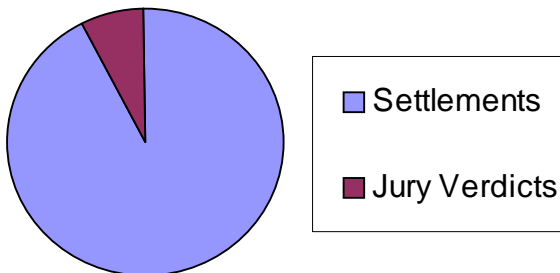
The failure of tort restrictions to control premium rates makes sense given that insurance companies do not base premium rates solely—or even necessarily primarily—on claim payouts.<sup>61</sup> Because lag time inevitably exists between an insurance company’s receipt of premiums and its obligation to pay claims,<sup>62</sup> the company invests paid-in premiums in a variety of schemes. Contrary to popular perceptions, the resulting investment income, rather than premium receipts, constitutes the bulk of the companies’ profits.<sup>63</sup> Consequently, even where malpractice claim payouts remain stable, insurance companies can incur significant losses by making poor or irresponsible investments. This is particularly true if companies have offered artificially low premium rates based on unjustifiably optimistic projections regarding the investment income that they could earn from attracting new insureds.

### Total Costs per Year, Including Defense Costs for Large Claims in Texas



Total cost (payout plus defense costs) for all nonduplicate large paid medical malpractice claims from 1988-2002 for the BRD dataset, adjusted for population growth, change in number of physicians, Texas GSP, and change in Texas real healthcare spending. Total costs for 1988 and 1989 are lower than the actual amounts due to incomplete reporting. Chart based on Figure 9 in the report on the Texas study, (cited in note 41), and underlying data provided by Professor Bernard Black.

### Awards of \$1 Million or More in Florida



In Florida from 1990-2003, 92.5 percent of medical malpractice awards for \$1 million or more came from settlements, and 7.5 percent from jury verdicts, as found by the Florida study cited in note 45.

As numerous articles have reported, this over-optimism story appears to describe exactly what transpired in the insurance industry before the latest “crisis.” The same time period during which medical liability claims remained stable also has been described in the spring of 2002 by *Wall Street Journal* reporter Christopher Oster as “a decade of imprudence among insurers—a period that combined a relentless price war with aggressive risk-taking.”<sup>64</sup> In his front-page story, Oster explained:

From 1993 to 2000, underwriters slashed rates, sometimes as much as 40 percent, and fought for customers by loosening terms on all types of business policies—from directors-and-officers’ liability coverage to medical-malpractice packages to workers’ compensation insurance. . . . Insurers eventually reached the limit. By 1999, they were paying out, on average, \$1.07 in claims and related expenses for every \$1 of premium received on business coverage. During the bull

market of the '90s, insurers could sustain these losses on underwriting because the shortfalls were more than offset by investment income the insurer earned on premiums. Now financial markets have soured, and so have insurers' investment yields.<sup>65</sup>

In short, having based their premium rates on unrealistic projections of payout obligations and income from high-risk investments in relatively new companies, such as Enron and WorldCom, whose shares were increasing at incredibly high rates,<sup>66</sup> insurance companies "began to double and triple the costs for doctors."<sup>67</sup> Thus, although payouts on medical malpractice claims are a component of insurance companies' profit-loss statement, they are not responsible for the recent steep increase in insurance company losses or the subsequent increase in premium rates that companies implemented in an attempt to make up for those losses. In calling for tort "reform," therefore, the insurance industry misleadingly conflates the whole with the part—skyrocketing losses are said to be driven by skyrocketing payouts on medical liability claims, when in fact the losses are driven by other factors.

Severely limiting the amounts that victims of medical malpractice are able to recover would no doubt decrease insurance companies' payouts, but those are the very sort of payouts that insurance companies are supposedly in the business of insuring.<sup>68</sup> Moreover, altering the civil justice system would do nothing to address the fact that "insurance companies got greedy"<sup>69</sup> in their investment and pricing strategies, and that those rash strategies seem most plausible as an explanation for the malpractice insurance premium crisis. In addition to such arguably negligent business practices, state and federal investigators continue to uncover evidence of deceptive accounting and other more questionable business practices within the insurance industry.<sup>70</sup> Malpractice victims should not have to pay for this "decade of imprudence" and deceit within the insurance industry. After all, the civil justice system does not exist to maximize insurance industry profits or to bail the industry out of a financial disaster that it has substantially created. Instead, it exists to provide victims with compensation, and to afford society a means of condemning past misconduct and deterring wrongful future acts. Insurance reform—and not medical liability "reform"—succeeded in stabilizing premium rates in California because it is the insurance industry—and not the civil justice system—that is out of control.<sup>71</sup>

### **III. There is not a 'lawsuit crisis.'**

Corporations, politicians, conservative think tanks, and various "Astroturf" organizations have attempted to

convince the public that the civil justice system is loaded to the breaking point with meritless tort claims. They have done so not by citing rigorous empirical evidence, but by repeating anecdotes of alleged lawsuit abuse<sup>72</sup> and by using vague descriptive terms such as "flood," "proliferation," and "explosion."<sup>73</sup> This avoidance of precision is not altogether surprising, given that available statistics indicate the number of tort filings has been declining since the beginning of the 1990s. In a recent report, for instance, the National Center for State Courts found that the number of tort claims filed in 35 states accounting for 77 percent of the U.S. population *dropped by 4 percent* during the period from 1993 to 2002.<sup>74</sup> When adjusted for population, the decline in tort filings over the same time period is even steeper: For the 31 states reporting adjusted data to the Center, the average change in the rate of tort filings per 100,000 people was a 13 percent decrease.<sup>75</sup>

Some context may be in order. First, the vast majority of civil claims are *not* tort claims. According to the most recent analysis by the Department of Justice's Bureau of Statistics, tort claims accounted for only 10 percent of civil filings in state courts in 1993 and have remained stable since 1986.<sup>76</sup> Second, the kind of tort claims that purportedly cause problems—i.e., medical malpractice and products liability claims—represent only a very small portion of the nation's total tort filings. The overwhelming majority of tort cases involve automobile accidents (60.1 percent), while the second largest category of tort filings concerns premises liability (17.3 percent).<sup>77</sup> Only 4.9 percent of the filings allege medical malpractice, and even less—3.4 percent—involve products liability.<sup>78</sup> Third, the category of tort litigation experiencing anything approaching an "explosion" appears to be businesses claiming trademark infringement, breach of contract, and *commercial* tort claims. In a recent study, Public Citizen found that "[b]usinesses file four times as many lawsuits as do individuals represented by trial attorneys."<sup>79</sup> Further evidence of corporate "litigiousness" is provided by the National Center for State Court's finding that from 1998 to 2002, the number of tort cases has been "overtaken" by the "steadily" rising number of contract cases,<sup>80</sup> which are more likely to involve businesses suing other businesses and which, unsurprisingly, are not a part of the civil justice system targeted for reform.

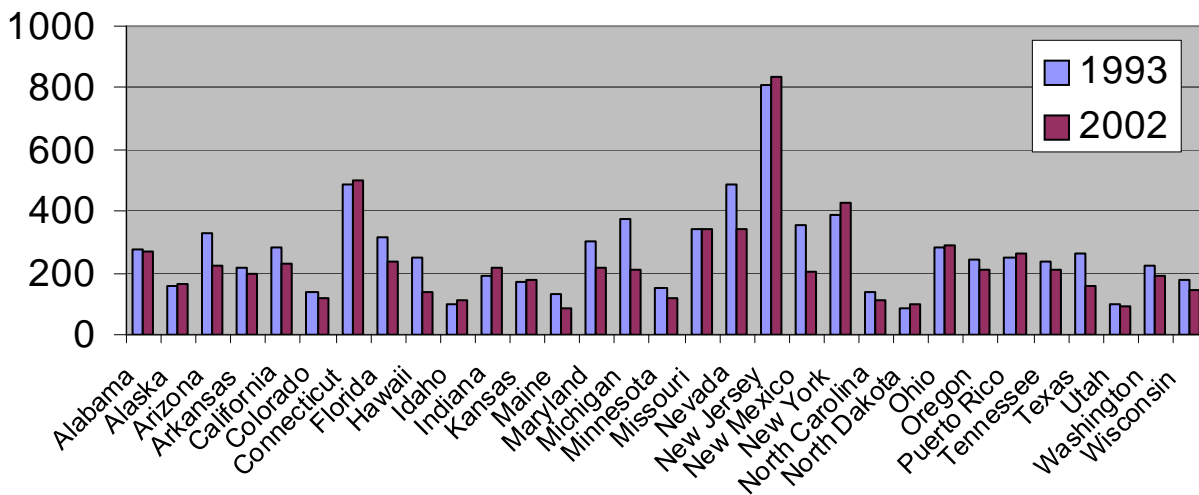
A recent study of medical malpractice litigation in Illinois<sup>81</sup> provides evidence that further refutes claims of a "lawsuit crisis," particularly those decrying out-of-control jury verdicts. The study's findings are particularly important in the debate about the civil justice system because two of the Illinois counties analyzed—Madison and St. Clair

Counties—were deemed, respectively, the number-one and number-two “judicial hellholes” by the American Tort Reform Association (“ATRA”),<sup>82</sup> the organization created and maintained by the tobacco industry and other big corporations to push for legislative restrictions on the tort system.<sup>83</sup> The ATRA coined “judicial hellholes” to refer to areas in the country where judges and juries are purportedly biased in favor of tort plaintiffs, resulting in unjustified verdicts in favor of plaintiffs and exorbitant damages awards.<sup>84</sup> But according to the Illinois study, plaintiffs prevailed in only 11 of the 40 trials involving medical malpractice claims in Madison and St. Clair Counties over the fourteen-year period from 1992 to 2005.<sup>85</sup> Put differently, medical malpractice plaintiffs have won a mere 28 percent of the time in the two top so-called “judicial hellholes.” Of these cases, only two damages awards exceeded \$1 million.<sup>86</sup> As the study’s author, Duke University Law School Professor Neil Vidmar, concluded, “[t]here is no evidence to support the perception that medical malpractice jury trials in these counties are frequent or that jury verdicts for plaintiffs are

outrageous,” and thus, “[i]nsofar as medical malpractice litigation is concerned, the reputation of Madison and St. Clair counties as ‘judicial hellholes’ is not justified.”<sup>87</sup>

Additional reasons for doubting the existence of “too much” litigation come from examining the larger judicial and societal contexts in which people are looking to courts for redress. Both federal and state court judges are empowered to weed out and deter baseless claims using special procedural rules as well as their inherent authority to discipline those appearing before them.<sup>88</sup> Rule 11 of the Federal Rules of Civil Procedure and its state analogues give judges discretion to impose a variety of sanctions—including reprimands, fines, dismissals of claims, and injunctions—in order to punish an offending party, deter similar misconduct, and compensate the other party for its unnecessary expenses.<sup>89</sup> Furthermore, as the U.S. Supreme Court has recognized, courts may issue sanctions for “a full range of litigation abuses” pursuant to their inherent judicial power, which predates and continues to exist alongside Rule 11.<sup>90</sup> Thus, “if in the informed discretion

### Growth Rates of Tort Filings in Unified and General Jurisdiction Trial Courts in 31 States, 1993 v. 2002



Number of tort filings per 100,000 people in 31 states in 1993 and 2002, as found by the National Center for State Courts report cited in note 74. “Unified” courts have jurisdiction over all tort cases, regardless of the amount of damages at stake, and “general” courts have jurisdiction over cases involving a statutorily prescribed minimum amount of damages.

of the court,” existing rules “are not up to the task, the court may safely rely on its inherent power” to impose sanctions for bad-faith conduct in litigation.<sup>91</sup> Unlike legislators working from Washington, federal and state judges using these devices to deter frivolous litigation can ensure that they are used only in appropriate cases, tailored specifically to the situation at hand.

Public Citizen recently undertook an examination of 100 cases in which federal judges throughout the country imposed sanctions pursuant to Rule 11 of the Federal Rules of Procedure. This survey revealed that businesses were 69 percent more likely than individual tort plaintiffs and their attorneys to be sanctioned for engaging in frivolous litigation.<sup>92</sup> This finding makes sense given that the contingency-fee system already provides a check on frivolous litigation by trial attorneys representing individual plaintiffs of modest or low income. While corporate attorneys typically are paid by the hour regardless of outcome, trial attorneys working on a contingency-fee basis are paid for their work only if their clients prevail. Furthermore, unlike corporate attorneys, trial attorneys must pay the costs of preparing and trying cases—often hundreds of thousands of dollars for medical malpractice cases<sup>93</sup>—and are not reimbursed unless the case is successful. As a trial attorney specializing in medical malpractice pointed out to a *New York Times* reporter: “In his speeches, Bush makes it sound as if every lawsuit that is brought is junk or frivolous. . . . But we do everything we can to weed out cases that are without merit. We have to. Our own money is at risk.”<sup>94</sup> This built-in control mechanism for the plaintiffs’ bar appears to be working well.

The absence of a lawsuit crisis calls into question the claims that doctors are practicing defensive medicine and leaving the medical profession out of fear of being sued. These two impressions are essential to the claim that the civil justice system is making healthcare more expensive and less accessible. That is because, even assuming that placing restrictions on the medical liability system would lead to decreased liability insurance premiums, the effect on healthcare spending would still be nominal. As the Congressional Budget Office (“CBO”) pointed out in a recent report analyzing the proposed federal medical malpractice legislation, “even large savings in premiums can have only a small direct impact on healthcare spending—private or governmental—because malpractice costs account for less than 2 percent of that spending.”<sup>95</sup> Thus, unless tort-change proponents make stronger claims about the effects of medical malpractice liability, their effort to link the healthcare crisis to a lawsuit crisis is simply

implausible. The problem for proponents of federal legislation is that evidence for the claims of defensive medicine and doctor flight is also “weak and inconclusive.”<sup>96</sup>

In making its claim that defensive medicine is driving up healthcare costs, the Bush administration relies on a 1996 study<sup>97</sup> that two non-partisan congressional research agencies have dismissed as unreliable. This is not surprising given the study’s methodology: researchers compared the costs of care for Medicare patients hospitalized for two types of heart disease in states with and without certain legislatively-imposed tort restrictions.<sup>98</sup> As the U.S. Government Accountability Office (“GAO”) pointed out in its 2003 report on the relationship between medical malpractice liability and access to healthcare, the Bush administration improperly extrapolated these limited findings to the entire nation:

[R]ecent reports by the U.S. Department of Health and Human Services. . . applied the 5 to 9 percent hospital costs savings estimate for Medicare patients to total national healthcare spending to estimate the total defensive medicine savings that could result if federal tort reforms were enacted. Because the 5 to 9 percent savings only applies to hospital costs for elderly patients treated for two types of heart disease, the savings cannot be generalized across all services, populations, and health conditions.<sup>99</sup>

The Bush administration relied solely on the 1996 study to estimate the national costs of “defensive medicine,” despite the obvious problems with projecting such limited findings onto the entire nation.

Subsequent studies with a broader scope have concluded that there is little or no evidence that fear of liability results in unnecessary medical expenditures. CBO “applied the methods used in the (1996) study of Medicare patients hospitalized for two types of heart disease to a broader set of ailments [and] found no evidence that restrictions on tort liability reduce medical spending.”<sup>100</sup> CBO confirmed this result in another analysis that “used a different set of data,” finding “no statistically significant difference in per capita healthcare spending between states with and without limits on malpractice torts.”<sup>101</sup> Two National Bureau of Economic Research (“NBER”) scholars examined the defensive-medicine claim with even more empirical precision by comparing physicians’ treatment patterns in light of states’ premium rates rather than states’ tort restrictions.<sup>102</sup> As the authors explain, the 1996 study is faulty because it “rel[ies] on indirect evidence

from tort reform, rather than direct evidence on malpractice costs themselves.<sup>103</sup> Based on a much wider array of information categories than that used in the 1996 study—including “the use of cesarean sections and several different treatments for Medicare enrollees over age 65 . . . as well as total Medicare expenditures by state”—the NBER scholars found “little evidence of change in treatment patterns in response to increases in premiums . . . .”<sup>104</sup>

It is also important to bear in mind that all of these studies implicitly assume that if increased usage of a procedure in response to the potential for malpractice liability were found, it would constitute “defensive medicine.” By this term, tort-change proponents mean to suggest that a treatment does not improve the quality of healthcare.<sup>105</sup> For example, the NBER scholars did find increased usage of mammography in Medicare patients in response to malpractice costs.<sup>106</sup> The researchers note that this “low-cost screening procedure” would have little effect on Medicare costs, a point that is consistent with their observation of “little increase in overall expenditures for the Medicare population.”<sup>107</sup> Moreover, the fact of increased usage by itself does not mean that the treatment is unjustified and will not heighten the quality of healthcare. Particularly where the increase is in low-cost procedures, such as mammography, that screen for diseases that are deadly if left untreated, one might think that this is precisely the kind of defensive medicine that society wants and needs.<sup>108</sup> There are, of course, concerns about the accumulated costs of thousands of screening tests, each of which individually appears desirable and necessary. But that is not a problem of “defensive medicine”; it is a problem of designing an equitable and sustainable healthcare system that serves the needs of all Americans, wealthy or poor, young or old, healthy or ill.<sup>109</sup> Solving that problem will be difficult and, even if it were successful, it would benefit millions of dispersed individuals rather than a concentrated group of wealthy corporations. It is easy to understand, then, how the fiction of defensive medicine became a “problem” worthy of national attention.

Like the phenomenon of so-called “defensive medicine,” there is no support for the alleged mass exodus of doctors from the medical profession. In fact, as GAO recently reported, not only has the number of physicians in this country been *increasing* for the past decade, the physician increase has outpaced the U.S. population increase.<sup>110</sup> According to GAO, “[t]he number of physicians in the United States increased about 26 percent from 1991 to 2001, twice as much as the nation’s population.”<sup>111</sup> Consequently, the number of physicians

adjusted for population (per 100,000 people) rose 12 percent from 1991 to 2001.<sup>112</sup> Furthermore, from 1996 to 2001—the period during which the recent malpractice premium spike occurred—the population-adjusted increase in the number of physicians was 2 percent higher than the population-adjusted physician increase from 1991 to 1996—the period during which insurance companies offered exceedingly low premiums as they vied for a larger market share during the stock market boom.<sup>113</sup>

It is difficult to reconcile the fact that the physician population is growing faster than the total U.S. population with claims of doctor flight and a resulting access problems.<sup>114</sup> When GAO attempted to confirm these claims empirically by conducting investigations in five AMA-deemed “crisis” states, the agency found that “many of the reported provider actions taken in response to malpractice pressures [could] not [be] substantiated or did not widely affect access to healthcare.”<sup>115</sup> In particular, GAO noted that, although there was “extensive media coverage” of reports by provider organizations that “some physicians in each of the five states are moving, retiring, or closing practices in response to malpractice pressures,” those reports were either “inaccurate or involved relatively few physicians” and thus “did not widely affect access to healthcare.”<sup>116</sup> In fact, the only access problems that GAO could “confirm[] were limited to scattered, often rural, locations and in most cases providers identified long-standing factors in addition to malpractice pressures that affected the availability of services.”<sup>117</sup>

Among the “doctor flight” anecdotes that GAO found to be untrue were some that involved obstetricians.<sup>118</sup> The AMA and the Bush administration recite such anecdotes with great frequency, appealing to the public’s understandable concern about the availability of readily accessible and quality healthcare to pregnant women. GAO’s findings are reinforced by Public Citizen’s investigation of the obstetrician-flight tales that the AMA included in its anti-malpractice-lawsuit testimony before Congress in October 2004. Public Citizen found, for example, that a Pennsylvania obstetrics unit remained open and accepting new patients two years after the AMA claimed it had shut down because of premium increases.<sup>119</sup> Similarly, a recent study found no support for media-documented claims of the flight of obstetrician-gynecologists and other physicians from Illinois in general or from the state’s two ATRA-designated “judicial hellhole” counties of Madison and St. Clair.<sup>120</sup> Rather, based on the AMA’s own statistics, the study’s author found that in Illinois, the number of obstetrician-gynecologists,

neurological surgeons, and other physicians “has increased steadily” in absolute terms as well as when adjusted for population growth from 1993 to 2003.<sup>121</sup> Thus, while it is true that physicians in certain fields, including that of obstetrics-gynecology, have faced particularly high premium rates in some states during the latest premium spike,<sup>122</sup> the evidence indicates that this has not resulted in widespread access problems due to provider flight.<sup>123</sup> Furthermore, a recent study shows that the premium hikes for obstetricians/gynecologists are not attributable to malpractice claims against these physicians. In its analysis of data from the National Practitioner Data Bank and the *Medical Liability Monitor*, Public Citizen found that since 1991, the median payout and total amount of damages paid by obstetricians/gynecologists have either declined or risen only at the same rate as the cost of medical care services.<sup>124</sup>

In addition to so-called defensive medicine, the NBER scholars addressed the question of whether the medical liability system has led to a decrease in the physician supply in this country. Their findings reinforce those of GAO: “On average, the size of the physician workforce in each state does not seem to respond to increases in premiums.”<sup>125</sup> The NBER study did find “weak evidence that some physicians on the margins of their careers make entry and exit decisions in part based on the size and number of malpractice payments,” and that malpractice costs increases “may [decrease] the size of the rural physician workforce.”<sup>126</sup> Nevertheless, even if some rural physicians quit or relocate because of malpractice insurance considerations, the number of physicians in both rural and urban areas has increased. Indeed, the number of rural physicians has increased at a higher rate than the number of urban physicians.<sup>127</sup>

Before issuing its report finding the medical establishment’s claims of “crisis” states to be unfounded, GAO solicited comments “from three independent health policy researchers and AMA.”<sup>128</sup> Although all three independent experts “generally concurred with [GAO’s] findings,” the “AMA questioned [the] finding that rising malpractice premiums have not contributed to widespread healthcare access problems, expressing concern that the scope of [GAO’s] work limited [its] ability to fully identify the extent to which malpractice-related pressures are affecting consumers’ access to healthcare.”<sup>129</sup> The AMA’s complaints included that “the small number of states (studied by GAO) doesn’t give an adequate picture of overall trends.”<sup>130</sup> However, as GAO pointed out in response to the AMA’s complaint, “because they are among the most visible and often-cited examples of ‘crisis’ states,”

“the experiences of these five states provide important insight into the overall problem.”<sup>131</sup> The important insight that we draw from these studies is that the healthcare crisis has been distorted in order to restrict the ability of the American public to seek redress for wrongful injury and to hold the perpetrators accountable in the civil justice system.

#### ***IV. There is an ongoing corporate campaign to convince the public that there is a lawsuit crisis.***

Facts notwithstanding, the notion that frivolous suits abound in U.S. courts appears to have taken root in the public’s mind. This is an astounding feat of propaganda considering that, only two decades ago, “Americans didn’t see lawsuits as a huge problem.”<sup>132</sup> When insurance and other corporations with an interest in immunizing themselves from lawsuits initiated their campaign against the civil justice system in the 1950s,<sup>133</sup> they sought to influence public opinion primarily through a barrage of advertisements decrying the purported irrationality of the civil justice system.<sup>134</sup> In time, corporate officials and their supporters sought to promulgate similar messages through apparently independent sources. In the mid-1980s, corporations began financing the generation of “evidence” of a lawsuit crisis by conservative think tanks. This evidence was intended primarily for use by journalists, thereby transforming the message of the industry-sponsored advertisements into “news.”<sup>135</sup>

The principal think tank that has served corporations in this capacity is the Manhattan Institute for Policy Research.<sup>136</sup> In 1986, the insurance industry bankrolled the creation of the Institute’s Project on Civil Justice Reform, “targeted specifically at journalists.”<sup>137</sup> As William Hammett, the Manhattan Institute’s president, stated in a 1992 memorandum explaining the project’s mission:

Journalists need copy, and it’s an established fact that they’ll “bend” in the direction in which it flows. For that reason, it is imperative that a steady stream of understandable research, analysis, and commentary supporting the need for liability reform be produced. If sometime during the present decade, a consensus emerges in favor of serious judicial reform, it will be because millions of minds have been changed, and only one institution is powerful enough to bring that about: the combined force of the nation’s print and broadcast media, the most potent instrument for public education—or miseducation—in existence.<sup>138</sup>

A critical component of the corporate-sponsored effort to foster the perception of a “lawsuit crisis” has been the recitation of misleading or outright false anecdotes about ridiculous suits brought by opportunistic plaintiffs and lawyers.<sup>139</sup> For example, one such anecdote frequently repeated in political speeches, business circles, and the mainstream media over the last twenty years mischaracterizes the medical malpractice case brought by a woman for injuries she suffered as a result of her severe allergic reaction to radioactive dye administered in preparation for a CAT scan.<sup>140</sup> According to numerous newspaper articles, scholarship produced by right-wing think tanks, and prominent politicians such as President Reagan, the jury awarded the plaintiff in the case, Judith Richardson Haimes, almost \$1 million for her claim that she lost her psychic powers because of a CAT scan.<sup>141</sup> In reality, Haimes presented the jury with evidence that the defendant radiologist downplayed Haimes’s warning that she had been advised to avoid iodine-based dyes because of a previous allergic reaction and pressured Haimes to consent to a test-run of a small dose of the dye.<sup>142</sup> Haimes never even underwent the CAT scan because the injection of the dye immediately sent her into anaphylactic shock, and she spent the next several days with severe nausea, vomiting, and debilitating headaches.<sup>143</sup> She testified that she continued to suffer from the severe headaches whenever she engaged in deep mental concentration, forcing her to quit practicing as a professional psychic.<sup>144</sup> Haimes asked for relief for the immediate pain and suffering she experienced as well as lost income, but the judge would not allow the jury to consider the lost-income claim because she did not offer expert testimony showing that the dye caused her continuing headaches.<sup>145</sup> Consequently, contrary to the widely-circulated version of the case, the jury’s verdict and award were not based on any allegations relating to Haimes’s work as a psychic. Also left out of the story that the public was repeatedly told by the media, politicians, and business leaders was that the judge vacated the award as excessive and ordered a new trial, which was dismissed after a different judge determined that Haimes’s medical expert did not have adequate qualifications.<sup>146</sup>

Tales such as the popularized version of the Haimes case, which amount to lies as a result of extreme simplification and selective omission of key information, not only command the attention of journalists because of their ready reducibility to eye-catching headlines, but they also serve to exclude from the tort “reform” debate the public benefits of the civil justice system. After all, no public benefits are apparent in anecdotes that invariably

portray plaintiffs, jurors, and trial attorneys as abusing the civil justice system rather than using the system to combat and prevent corporate malfeasance. In the case of medical malpractice liability, doctors and trade associations for healthcare providers have employed a similar strategy to capture headlines and arouse public concern by broadly distributing anecdotal evidence of widespread practice of defensive medicine and flight of doctors.<sup>147</sup> As Stephanie Mencimer notes in her *Washington Monthly* investigative article on the recent push for national legislation limiting medical malpractice liability, “[a]ll across the country, doctors . . . are telling reporters, legislators, and even their patients that frivolous lawsuits are driving up insurance costs and driving doctors out of practice and out of state, threatening access to care.”<sup>148</sup> Limiting lawsuits against negligent doctors is politically expedient because it shifts “blame onto the Democrats, who have long enjoyed greater public trust on the issues,” and it uses “doctors as a cudgel against trial lawyers, the Democratic Party’s second-largest funding base.”<sup>149</sup> Tort restrictions not only take money away from Democrats, but they also make a significant amount of money available to Republicans. Karl Rove, President Bush’s primary political adviser since his tenure as Texas governor, understands this dual political advantage well. When Rove “talked” Bush into adding tort “reform” to his campaign platform for his 1994 bid for the Texas governorship, Rove was also serving as a consultant to the tobacco giant Phillip Morris.<sup>150</sup> The tobacco industry has pumped staggering amounts of cash into the tort “reform” movement.<sup>151</sup> The promise of tort restrictions has continued to prove lucrative for the Republicans now that Bush (and Rove) have moved into the White House. Over the past two years, contributions to Republican political candidates by healthcare professionals and the insurance industry have been about double those to Democrats.<sup>152</sup>

## V. Conclusion

As we have seen, America does face a healthcare crisis, visible not only in the form of skyrocketing costs and lack of healthcare insurance, but also in the form of widespread medical error that goes unrecognized and uncorrected. We have also seen that America faces a medical malpractice insurance crisis, as insurance companies have succeeded in distracting legislatures and voters from the kind of insurance reform that has been shown to control costs and to deter careless or even fraudulent investment behavior by insurance companies. What we have not seen, however, is a lawsuit crisis.

Physicians understandably regard the civil justice system with unease. Having devoted themselves to a life of study and practice in service of public health, physicians see the civil justice system as society's ungrateful and misinformed attempt to second-guess their work. But much of the necessity of the civil justice system to protect society from medical malpractice is driven by the doctors' own professional associations' failure to self-regulate. Moreover, in joining forces with insurance companies and other large healthcare corporations, physician groups have overlooked the opportunity to join with consumers, taxpayers, and citizens in an effort to overturn the powerful corporate healthcare alliance that has plunged the nation into a medical and financial crisis. Tort restrictions benefit the insurance industry and healthcare companies not only by providing them with immunity, but also by preserving the status quo of a healthcare system in which these corporate actors currently face few influences besides tort law on their decisionmaking. As explained in a *Washington Post* opinion article by George Silver, a professor of public health at Yale University School of Medicine, the modern healthcare system is dominated by "industrial giants, many of them publicly traded, [who] have been enticed to the table by the promise of large

profits and guarantees of total federal immunity from efforts to regulate their practices and businesses."<sup>153</sup> Restricting medical malpractice liability means that standards of care will be left almost entirely in the hands of these giant insurance companies and for-profit HMOs.

The Congressional Office of Technology warned about this potential whipsaw in a 1994 report, noting that, "[g]iven new incentives to do less rather than more" in a healthcare system largely controlled by profit-driven HMOs and insurance companies, restrictions on malpractice liability "that reduce or remove incentives to practice defensively could reduce or remove a deterrent to providing too little care at the very time that such mechanisms are needed."<sup>154</sup> Thus, if the Bush administration and its corporate supporters succeed in imposing nationwide malpractice liability restrictions, a predictable result will be that injury and suffering from medical negligence will rise. Given the absence of other means of regulatory oversight, the failure of the medical profession itself to regulate adequately physician quality, and the increasing consolidation of the healthcare industry, tort law stands as an essential component of the overall healthcare framework.

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## Endnotes

- 1 See President George W. Bush, State of the Union Address (Feb. 2, 2005) (transcript at <http://www.whitehouse.gov/news/releases/2005/02/20050202-11.html>) (“Justice is distorted, and our economy is held back by irresponsible class-actions and frivolous asbestos claims—and I urge Congress to pass legal reforms this year. . . . I ask Congress to move forward on. . . medical liability reform that will reduce health care costs and make sure patients have the doctors and care they need.”) [hereinafter Bush State of the Union Address]; see also, e.g., Jeffrey H. Birnbaum & John F. Harris, *President’s Proposed Remedy to Curb Medical Malpractice Lawsuits Stalls*, WASH. POST, Apr. 3, 2005, at A5.
- 2 See WILLIAM HALTOM & MICHAEL McCANN, DISTORTING THE LAW: POLITICS, MEDIA, AND THE LITIGATION CRISIS 36 (2004); Daphne Eviatar, *Is Litigation a Blight, or Built In?*, N.Y. TIMES, Nov. 23, 2002, at B1.
- 3 See Stephanie Mencimer, *False Alarm: How the Media Helps the Insurance Industry and the GOP Promote the Myth of America’s “Lawsuit Crisis”*, WASH. MONTHLY (Oct. 2004) [hereinafter Mencimer, *False Alarm*].
- 4 Dan Zegart, *The Right Wing’s Drive for ‘Tort Reform’*, THE NATION, Oct. 25, 2004, at 15.
- 5 Because “reform” means “[t]o improve by alteration, correction of error, or removal of defects,” AMERICAN HERITAGE DICTIONARY (4<sup>th</sup> ed. 2000), the use of that term to describe changes to the civil justice system begs the question that this paper addresses. Accordingly, we use more neutral terms, such as “change.”
- 6 See Knight Ridder, Ron Hutcherson, *Plaintiffs Say Bush Ignoring Them in Campaign for Lawsuit Reform* (Jan. 6, 2005).
- 7 See Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2005, H.R. 534, 109<sup>th</sup> Cong. § 9(7) [hereinafter HEALTH Act]. The Senate bill—S. 354—has the same title and language as the House bill; the bills differ only in their section numbering. The sections referenced below are in those in the House bill.
- 8 For a list of the types of restriction on medical malpractice liability that have been enacted in each state, see J. ROBERT HUNTER & JOANNE DOROSHOW, CTR. FOR JUSTICE & DEMOCRACY, PREMIUM DECEIT: THE FAILURE OF “TORT REFORM” TO CUT INSURANCE PRICES at app. A—Medical Malpractice “Tort Reforms” (2002).
- 9 See Steve Teske, *Frist Willing to Discuss Insurance Reforms to Move Malpractice Legislation This Year*, 14 Health L. Rep. (BNA) 360 (Mar. 17, 2005).
- 10 *Id.*
- 11 Robert Pear, *Bush Begins Drive to Limit Malpractice Suit Awards*, N.Y. TIMES, Jan. 5, 2005.
- 12 See 2005 HISTORY OF BILLS ONLINE VIA GPO ACCESS, at <http://frwebgate5.access.gpo.gov/cgi-bin/waisgate.cgi?WAISdocID=588010216737+0+0+0&WAISSaction=retrieve> (House); <http://frwebgate1.access.gpo.gov/cgi-bin/waisgate.cgi?WAISdocID=58782084922+0+0+0&WAISSaction=retrieve> (Senate).
- 13 HEALTH Act, *supra* note 7, § 4(b).
- 14 See *id.* § 7.
- 15 *Id.* § 3.
- 16 See *id.* § 5.
- 17 President George W. Bush, Speech at the Gateway Center in Collinsville, Ill. (Jan. 5, 2005) (transcript and video at <http://www.whitehouse.gov/news/releases/2005/01/20050105-4.html>) [hereinafter Bush Collinsville Speech].
- 18 DANIEL P. KESSLER & DANIEL L. RUBINFELD, EMPIRICAL STUDY OF THE CIVIL JUSTICE SYSTEM 9 (Nat’l Bureau of Econ. Research, Working Paper No. 10825, 2004) (citing INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (1999)).
- 19 INST. OF MED., REPORT SUMMARY: TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (1999), available at <http://www.iom.edu/Object.File/Master/4/117/0.pdf>.
- 20 Robert S. Peck, *Tort Reform’s Threat to an Independent Judiciary*, 33 RUTGERS L.J. 835, 850 (2002) (quoting INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 2 (1999)).
- 21 CONG. BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE 7 (Jan. 2004) [hereinafter CBO, LIMITING MEDICAL MALPRACTICE LIABILITY].
- 22 See PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 62 (1993). Further, as CBO points out, the 27,179 total cases of negligence “included 5,396 with strong evidence that the negligence contributed to patient disabilities of six months or more—and the estimated 415 claims actually filed correspond to just 7.7 percent of that smaller number of cases.” CBO, LIMITING MEDICAL MALPRACTICE LIABILITY, *supra* note 21, at 7 n.19.
- 23 See NAT’L CTR. FOR STATE CTS, EXAMINING THE WORK OF STATE COURTS, 2002, at 28 (Brian J. Ostrom et al., eds., 2003), available at [http://www.ncsconline.org/D\\_Research/csp/2002\\_Files/2002\\_Tort\\_Contract.pdf](http://www.ncsconline.org/D_Research/csp/2002_Files/2002_Tort_Contract.pdf).
- 24 See Cheryl W. Thompson, *Medical Boards Let Physicians Practice Despite Drug Abuse*, WASH. POST, Apr. 10, 2005, at A1 [hereinafter Thompson, *Medical Boards*].
- 25 See PUB. CITIZEN, STOPPING REPEAT OFFENDERS: THE KEY TO CUTTING MEDICAL MALPRACTICE COSTS (2002), at <http://www.citizen.org/congress/civjus/medmal/articles.cfm?ID=8308>.
- 26 See Stephanie Mencimer, *Malpractice Makes Perfect: How the GOP Milks a Phony Doctors’ Insurance Crisis*, WASH. MONTHLY, Oct. 1, 2003 [hereinafter Mencimer, *Malpractice Makes Perfect*].
- 27 See Sidney M. Wolfe, *Bad Doctors Get a Free Ride*, N.Y. TIMES, Mar. 4, 2003, at A27.

- 28 Thompson, *Medical Boards*, *supra* note 24.
- 29 *Id.*
- 30 Cheryl W. Thompson, *Poor Performance Records Are Easily Outdistanced*, WASH. POST, Apr. 12, 2005, at A1.
- 31 *See id.*
- 32 Wolfe, *supra* note 27.
- 33 *Id.*
- 34 *See, e.g.*, CBO, LIMITING MEDICAL MALPRACTICE LIABILITY, *supra* note 21, at 1; U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES (GAO-03-702, June 2003), at 3, available at <http://www.gao.gov/new.items/d03702.pdf> [hereinafter GAO, MEDICAL MALPRACTICE PREMIUM INCREASE].
- 35 Ceci Connolly, *Malpractice Situation Not Dire, Study Finds*, WASH. POST, Mar. 10, 2005, at A8.
- 36 *See* Stephanie Mencimer, “*Tort Reform*” *Lone Star Style: What Tort Reform Did to Texas—And What It Could Do to America*, SOUTHERN EXPOSURE, Oct. 2004, available at <http://www.southernstudies.org/reports/TortReformOct04.pdf> [hereinafter Mencimer, “*Tort Reform*” *Lone Star Style*]. In contrast to the 1995 legislation restricting Texas citizens’ right to seek judicial redress for wrongful injuries, the Texas legislature passed much-needed legislation two years later creating a statutory cause of action against health insurance carriers, health maintenance organizations, and other companies that manage healthcare plans for injuries caused by negligent healthcare treatment decisions. *See* Texas Health Care Liability Act, TEX. CIV. PRAC. & REM. § 88.002(a) (Vernon Supp. 2004). However, the Supreme Court recently held that this Texas law was preempted by the federal Employee Retirement Income Security Act (“ERISA”). *AETNA Health Inc. v. Davila*, 124 S. Ct. 2488, 2502 (2004). As Justice Ginsburg pointed out in her concurring opinion, the Court’s expansive interpretation of the preemptive effect of ERISA in cases preceding *Davila* has resulted in a “regulatory vacuum” because adequate alternative remedies are not provided by ERISA as interpreted by the Court. *Id.* at 2503 (Ginsburg, J., concurring). Such absence of remedies for and protection against medical injuries caused by HMOs underscores the necessity of considering the proposed federal medical malpractice liability restrictions in light of the lack of effective alternative means of protecting malpractice victims, as discussed *supra*, Part I and *infra*, Part V.
- 37 *See*, for example, Bruce L. Ehni, *Prescription: Lower Legal Awards*, STAR-TELEGRAM (Fort Worth), Apr. 13, 2003, available at <http://www.dfw.com/mld/startelegram/news/editorial/5624585.htm>, an op-ed written by a neurosurgeon and member of Citizens Against Lawsuit Abuse, a grassroots-sounding name providing a front for the corporations that created and continue to fund the group.
- 38 Connolly, *supra* note 35.
- 39 Bernard Black et al., *False Diagnosis*, N.Y. TIMES, Mar. 10, 2005.
- 40 *Id.*
- 41 *See* BERNARD BLACK ET AL., STABILITY, NOT CRISIS: MEDICAL MALPRACTICE CLAIM OUTCOMES IN TEXAS, 1988-2002, at 2 (Social Science Research Network Electronic Library, Mar. 2005), at <http://ssrn.com/abstract=678601>.
- 42 *See Assessing the Need to Enact Medical Liability Reform: Hearing Before the House Subcomm. on Health of the Comm. on Energy and Commerce*, 108<sup>th</sup> Cong. (Feb. 10, 2003), at 14, available at <http://energycommerce.house.gov/108/hearings/02272003Hearing796/rosenfield.pdf> (statement of Harvey Rosenfield, President of the Foundation for Taxpayer and Consumer Rights) [hereinafter *Rosenfield Testimony at House Hearing on Medical Liability Reform*].
- 43 Stephanie Horvath, *Study Finds Tort Reform Not the Answer for Medical Malpractice Crisis*, PALM BEACH POST, Mar. 22, 2005.
- 44 *See* BestWire Serv., *Florida Weighs Giving Consumer Agency Oversight of Medical Malpractice Rates* (Feb. 9, 2004); Bestwire Serv., *Despite Malpractice Reforms, Florida Clears Huge Rate Hike* (Jan. 5, 2004).
- 45 *See* Neil Vidmar et al., *Uncovering the “Invisible” Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL L. REV. 315 (2005). Compare M. Alexander Otto, *No Malpractice Crisis, Report Says*, NEWS TRIBUNE (Tacoma, Wash.), Mar. 2, 2005, which summarizes the findings of Washington’s insurance commissioner that “[r]unaway lawsuits and out-of-control jury awards are not responsible for rising malpractice insurance rates that some doctors say are driving them out of business.” *Id.*
- 46 *See* Vidmar et al., *supra* note 45, at 334-336 & n.103. There was a small increase in the average number of paid claims per capita from 1995 to 1998 (specifically, about two more claims per 100,000 persons). *See id.*
- 47 *See id.* at 337.
- 48 *See id.* at 338-44, 354-55.
- 49 *See id.* at 349-50.
- 50 *See id.*
- 51 *Id.* at 355.
- 52 Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393, 394, 402-07 (2005); *see also* Joseph B. Treaster & Joel Brinkley, *Behind Those Medical Malpractice Rates*, N.Y. TIMES, Feb. 22, 2005, at C1; THOMAS H. COHEN, DEP’T OF JUSTICE BUREAU OF JUSTICE STATISTICS, MEDICAL MALPRACTICE TRIAL AND VERDICTS IN LARGE COUNTIES, 2001, at 2 (Apr. 2004), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mmtvcl01.pdf> (reporting that, in the 75 most populous counties in the United States, “[t]he number of medical malpractice jury trials since 1992 has remained stable”).
- 53 Treaster & Brinkley, *supra* note 52.
- 54 Horvath, *supra* note 43.
- 55 *Id.*

56 See Baker, *supra* note 52, at 394.

57 See Bush Collinsville Speech, *supra* note 17.

58 *Id.*

59 *Rosenfield Testimony at House Hearing on Medical Liability Reform*, *supra* note 42, at 3; see also *id.* at 9-10. Like California's MICRA statute, other states' tort "reform" measures do not appear to have affected premium rates, as confirmed by a recent study of insurance rate activity in every state from 1985 to 1998. See J. ROBERT HUNTER & JOANNE DOROSHOW, CTR. FOR JUST. & DEMOCRACY, PREMIUM DECEIT: THE FAILURE OF "TORT REFORM" TO CUT INSURANCE PRICES 2 (2002).

60 See *Rosenfield Testimony at House Hearing on Medical Liability Reform*, *supra* note 42, at 8.

61 See generally GAO, MEDICAL MALPRACTICE PREMIUM INCREASE, *supra* note 34, at 7, 15-17.

62 See Baker, *supra* note 52, at 398; KATHERINE BAICKER & AMITABH CHANDRA, THE EFFECT OF MALPRACTICE LIABILITY ON THE DELIVERY OF HEALTH CARE 5 (Nat'l Bureau of Econ. Research, Working Paper No. 10709, Aug. 2004).

63 See AMS. FOR INS. REFORM, MEDICAL MALPRACTICE INSURANCE: STABLE LOSSES/UNSTABLE RATES 2004, *Introduction and Summary of Findings*, at 3 (Oct. 2004), at [http://www.insurance\\_reform.org/StableLosses04.pdf](http://www.insurance_reform.org/StableLosses04.pdf).

64 Christopher Oster, *Insurance Costs Loom as Cloud Over the Economy*, WALL ST. J., Apr. 11, 2002, at A1.

65 *Id.*

66 For example, St. Paul, one of the largest of the financially-troubled medical malpractice insurers, lost \$108 million as a result of Enron's demise. Press Release, Office of Sen. Edward M. Kennedy, Statement in Opposition to the Medical Malpractice Amendment (July 26, 2002), at <http://www.senate.gov/~kennedy/statements/02/07/2002730306.html>. Insurance companies' high level of investment in companies that were part of the 1990s stock market bubble was contrary to industry standards directing insurers to rely primarily on conservative investments, such as government bonds. See Luke Metzger & David Bradley, *Insurance Industry Gambled Our Money and Lost*, Hous. Chron., Jan. 7, 2003.

67 Treaster & Brinkley, *supra* note 52.

68 The insurance industry and other tort-change proponents implicitly acknowledge this by framing their argument as one against frivolous suits.

69 Metzger & Bradley, *supra* note 66.

70 The extent of the mismanagement by American International Group, one of world's largest insurance companies and a leading malpractice insurer, is instructive. See, e.g., Jenny Anderson, *Insurer Admits Bad Accounting in Several Deals*, N.Y. TIMES, Mar. 31, 2005. After being subject to extensive investigation, AIG has finally

admitted "that its accounting for a number of transactions . . . was improper." *Id.*; see also CTR. FOR JUST. & DEMOCRACY, MEDICAL MALPRACTICE MISMANAGEMENT—WHY SOME MAJOR INSURERS HAVE PULLED OUT OF THE MARKET, at <http://www.centerjd.org/free/medmalmanagement.pdf> (last visited Mar. 30, 2005).

71 Importantly, Proposition 103 (California's insurance reform legislation) requires insurance companies to obtain the state insurance department's approval before increasing or decreasing premium rates, see *Rosenfield Testimony at House Hearing on Medical Liability Reform*, *supra* note 42, at 8, which enables state regulators to prevent companies from placing themselves (and their policyholders) in a precarious financial position by artificially lowering rates to secure a market share.

72 See, e.g., HALTOM & MCCANN, *supra* note 2, at 52 (noting that the tort-"reform" campaign has "shaped common sense less by rigorous arguments and systematic measurements than by skillful rhetoric, alluring narratives, and consistent convictions and that "remarkable encapsulations of ideological and moral critiques of the modern tort regime persist in 'tort tales,' anecdotes and horror stories about civil litigation in the United States")

73 See, e.g., WALTER K. OLSON, THE LITIGATION EXPLOSION: WHAT HAPPENED WHEN AMERICA UNLEASHED THE LAWSUIT (1991); David E. Bernstein, *Procedural Tort Reform: Lessons from Other Nations*, REG.: CATO REV. OF BUS. & GOV'T, Jan. 21, 2004, available at <http://www.cato.org/pubs/regulation/reg19n1e.html>; Joseph Perkins, *We All Pay When Others File Frivolous Lawsuits*, at Citizens Against Lawsuit Abuse website, <http://www.calahouston.org/perkins.html> (last visited Mar. 16, 2005).

74 NAT'L CTR. FOR STATE CTS., EXAMINING THE WORK OF STATE COURTS, 2003, at 23 (2004), available at [http://www.ncsconline.org/D\\_Research/csp/2003\\_Files/2003\\_SubCivil-TORTCON.pdf](http://www.ncsconline.org/D_Research/csp/2003_Files/2003_SubCivil-TORTCON.pdf) [hereinafter NCSC, EXAMINING THE WORK OF STATE COURTS].

75 See *id.* at 24, tbl.

76 STEVEN K. SMITH ET AL., DEP'T OF JUSTICE BUREAU OF JUSTICE STATISTICS, TORT CASES IN LARGE COUNTIES 2 (Apr. 1995), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/tclic.pdf>. Most civil filings in 1993—41 percent—were for cases involving domestic relations, such as divorce and child custody. *Id.*

77 *Id.*

78 *Id.*

79 See PUB. CITIZEN, FREQUENT FILERS: CORPORATE HYPOCRISY IN ACCESSING THE COURTS 5 (Oct. 2004), available at [http://www.citizen.org/documents/Frequent\\_Filers\\_FINAL.pdf](http://www.citizen.org/documents/Frequent_Filers_FINAL.pdf) [hereinafter PUB. CITIZEN, FREQUENT FILERS].

80 NCSC, EXAMINING THE WORK OF STATE COURTS, *supra* note 74, at 23.

81 NEIL VIDMAR, MEDICAL MALPRACTICE AND THE TORT SYSTEM IN ILLINOIS: A REPORT TO THE ILLINOIS STATE BAR ASSOCIATION (May 2005), at <http://www.isba.org/downloadnow/medicalmalpracticestudy.pdf>.

82. See AM. TORT REFORM ASS'N, JUDICIAL HELLHOLES 2004, at 7, 14-21 (2004), at <http://www.atra.org/reports/hellholes/report.pdf> [hereinafter ATRA, JUDICIAL HELLHOLES].
83. See Carl Deal & Joanne Doroshow, *Corporate Astroturf and Civil Justice: The Corporations Behind "Citizens Against Lawsuit Abuse"*, MULTINAT'L MONITOR, Mar. 2003, at 18.
84. See ATRA, JUDICIAL HELLHOLES, *supra* note 82, at 6, 8.
85. See VIDMAR, *supra* note 81, at 52 & tbl. 4.1, 58 tbl. 4.2, 64.
86. *Id.* at 64.
87. *Id.* at ii.
88. See FED. R. CIV. PROC. 11(b)-(c); Byron C. Keeling, *Toward a Balanced Approach to 'Frivolous' Litigation: A Critical Review of Federal Rule 11 and State Sanctions Provisions*, 21 PEPP. L. REV. 1067, 1072-73 (1994).
89. See CHARLES ALAN WRIGHT & ARTHUR R. MILLER, FEDERAL PRACTICE & PROCEDURE § 1336.3 (2004); PUB. CITIZEN, FREQUENT FILERS, *supra* note 79, at 11.
90. *Chambers v. NASCO, Inc.*, 501 U.S. 32, 46 (1991).
91. *Id.* at 50.
92. PUB. CITIZEN, FREQUENT FILERS, *supra* note 79, at 11.
93. See Steve Lohr, *Bush's Next Target: Malpractice Lawyers*, N.Y. TIMES, Feb. 27, 2005.
94. *Id.*
95. CBO, LIMITING MEDICAL MALPRACTICE LIABILITY, *supra* note 21, at 1.
96. *Id.*
97. Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q. J. ECON. 353 (1996). The administration laid out the basis for its claim that the medical liability system is the primary cause of rising healthcare costs in a 2002 Department of Health and Human Services report. This report deems Kessler and McClellan's 1996 piece "[t]he leading study" on the costs of defensive medicine and uses their estimate of the costs of defensive medicine as support for medical liability restrictions. DEP'T OF HEALTH & HUM. SERVS., CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 7 & n.28 (2002), available at <http://aspe.hhs.gov/daltcp/reports/litrefm.pdf>.
98. See CBO, LIMITING MEDICAL MALPRACTICE LIABILITY, *supra* note 21, at 6 & n.15.
99. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 29-30 (GAO-03-836, Aug. 2003), available at <http://www.gao.gov/new.items/d03836.pdf> [hereinafter GAO, IMPLICATIONS OF RISING PREMIUMS ON ACCESS].
100. CBO, LIMITING MEDICAL MALPRACTICE LIABILITY, *supra* note 21, at 6.
101. *Id.* at 6-7.
102. See KATHERINE BAICKER & AMITABH CHANDRA, THE EFFECT OF MALPRACTICE LIABILITY ON THE DELIVERY OF HEALTH CARE 8-9 (Nat'l Bureau of Econ. Research, Working Paper No. 10709, Aug. 2004).
103. *Id.* at 2.
104. *Id.* at 18.
105. See, e.g., Bush Collinsville Speech, *supra* note 17 (alleging that doctors are "writing prescriptions or ordering tests that really aren't necessary, just to reduce the potential of a future lawsuit").
106. BAICKER & CHANDRA, *supra* note 102, at 19.
107. *Id.*
108. It is also impossible to design a study examining rates of procedure usage that controls for motivating factors other than fear of liability. As CBO pointed out, "some so-called defensive-medicine may be motivated less by liability concerns than by the income it generates for physicians or by the positive (albeit small) benefits to patients." CBO, LIMITING MEDICAL MALPRACTICE LIABILITY, *supra* note 21, at 6.
109. Approximately one in six Americans currently lack healthcare insurance. See Press Release, Ctr. on Budget & Pol'y Priorities, Census Data Show Poverty Increased, Income Stagnated, and the Number of Uninsured Rose to a Record Level in 2003 (Aug. 27, 2004), at <http://www.cbpp.org/8-26-04pov.htm>.
110. U.S. GEN. ACCOUNTING OFFICE, PHYSICIAN WORKFORCE 2, 7 (GAO-04-124, Oct. 2003), available at <http://www.gao.gov/new.items/d04124.pdf> [hereinafter GAO, PHYSICIAN WORKFORCE].
111. *Id.* at 2.
112. *Id.* at 7. GAO also found that, even though the physician supply has significantly increased over the past decade in both metropolitan and non-metropolitan areas, "the disparity in the supply of physicians per 100,000 people between [the two] areas persisted because physicians continued to disproportionately locate in metropolitan areas." *Id.* at 18-19. As GAO pointed out, however, the geographic disparity in physician supply is a long-standing problem that the U.S. government has been trying to address through various programs for decades. See *id.* at 5-6; see also Geoff Boehm, *Debunking Medical Malpractice Myths: Unraveling the False Premises Behind "Tort Reform"*, 5 YALE J. HEALTH POL'Y, L. & ETHICS 357, 361 (2005).
113. See GAO, PHYSICIAN WORKFORCE, *supra* note 110, at 7 n.15.
114. See, e.g., AM. MED. ASS'N, MEDICAL LIABILITY CRISIS MAP, at <http://www.ama-assn.org/ama/noindex/category/11871.html> (updated Mar. 15, 2005).

- 115 GAO, IMPLICATIONS OF RISING PREMIUMS ON ACCESS, *supra* note 99, at 5. More specifically, “[t]he five states with reported problems are Florida, Mississippi, Nevada, Pennsylvania, and West Virginia.” *Id.* at 3 n.3.
- 116 *Id.* at 16-17.
- 117 *Id.* at 13.
- 118 *See id.* at 18.
- 119 *See* Letter from Joan Claybrook, President, Pub. Citizen, to Senators William Frist & John Ensign 2 (Apr. 6, 2004), available at [http://www.citizen.org/documents/Letter\\_to\\_Frist\\_on\\_AMA\\_04-06-04.pdf](http://www.citizen.org/documents/Letter_to_Frist_on_AMA_04-06-04.pdf).
- 120 *See* VIDMAR, *supra* note 81, at ii, 74-82.
- 121 *Id.* at ii, 82-83.
- 122 *See* Rita Rubin, *Fed-up Obstetricians Look for a Way Out*, USA TODAY, June 30, 2002.
- 123 It bears mention that healthcare is improved when actual malpractice suits—rather than premium increases—lead a physician who has repeatedly committed malpractice to leave the practice of medicine. For example, Compton Girdharry, an obstetrician-gynecologist from Ohio whom Bush invited to share the stage with him at an anti-lawsuit speech, told the crowd that he quit medicine because of high malpractice premiums. *See* Bob Herbert, *Not So Frivolous*, N.Y. TIMES, June 18, 2004. It turns out, however, that “[s]ince the early 1990s, [Girdharry] has settled lawsuits and agreed to the payment of damages in a number of malpractice cases in which patients suffered horrible injuries.” *Id.*
- 124 PUB. CITIZEN, DATA SHOWS RISING OB/GYN LIABILITY PREMIUMS NOT CAUSED BY MEDICAL MALPRACTICE LAWSUITS 1 (Feb. 2004), available at <http://www.citizen.org/documents/ACF42D4.pdf>.
- 125 BAICKER & CHANDRA, *supra* note 102, at 17.
- 126 *Id.* at 17, 20.
- 127 *See* GAO, PHYSICIAN WORKFORCE, *supra* note 110, at 12.
- 128 GAO, IMPLICATIONS OF RISING PREMIUMS ON ACCESS, *supra* note 99, at 38.
- 129 *Id.*
- 130 Tanya Albert, *GAO Report Calls Liability Crisis Localized*, AM. MED. NEWS, Sept. 22-29, 2004, at <http://www.ama-assn.org/amednews/2003/09/22/gvsb0922.htm>; *see also* GAO, IMPLICATIONS OF RISING PREMIUMS ON ACCESS, *supra* note 99, at 38.
- 131 GAO, IMPLICATIONS OF RISING PREMIUMS ON ACCESS, *supra* note 99, at 7. The AMA also questioned other aspects of GAO’s methodology and the reliability of the data underlying the agency’s findings, but GAO disagreed with these criticisms as well. *See id.* at 38.
- 132 Mencimer, *False Alarm*, *supra* note 3.
- 133 *See supra* note 3 and accompanying text.
- 134 *See* Mencimer, *False Alarm*, *supra* note 3.
- 135 *See id.*
- 136 *See* HALTOM & MICHAEL McCANN, *supra* note 2, at 40; Mencimer, *False Alarm*, *supra* note 3.
- 137 Mencimer, *False Alarm*, *supra* note 3.
- 138 *Id.*
- 139 *See, e.g.*, Neil de Mause, *Trial by Anecdote: Newsweek’s “Lawsuit Explosion” Blown Away by Facts*, EXTRA!, Mar./Apr. 2004, at 23 (reporting on the false and misleading nature of the anecdotes in *Newsweek’s* 2003 cover story *Lawsuit Hell: How Fear of Litigation is Paralyzing Our Professions*).
- 140 *See* HALTOM & MICHAEL McCANN, *supra* note 2, at 1-4.
- 141 *See id.* at 2-4. Haltom and McCann cite a 1986 *Los Angeles Times* headline as typical of the news accounts of the Haimes case: “Says Her Powers Vanished, ‘Psychic’ Awarded \$988,000 in Hospital CAT-Scan Lawsuit.” *Id.* at 2.
- 142 *Id.* at 1.
- 143 *Id.*
- 144 *Id.* at 2. Haltom and McCann note that “[n]ational and local law enforcement officials affirmed that [Haimes] in the past had aided them in solving crimes through use of her unusual gifts, a legacy well documented for some time by Philadelphia media.” *Id.*
- 145 *Id.*
- 146 *Id.*
- 147 *See, e.g.*, *West Virginia Surgeons Protest High Malpractice Insurance Rates; Pennsylvania Governor-Elect Offers Proposal*, DAILY HEALTH POL’Y REP. (Kaiser Family Found./Kaisernetwork.org), Jan. 2, 2003, at [http://www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?hint=3&DR\\_ID=15293](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=15293).
- 148 Mencimer, *Malpractice Makes Perfect*, *supra* note 26.
- 149 *Id.*
- 150 Dana Milbank, *The Political Mind Behind Tort Reform*, WASH. POST, Feb. 25, 2003, at A21.
- 151 As noted in HALTOM & McCANN, *supra* note 2, “tobacco companies have long been major financial supporters of the tort reform cause.” *Id.* at 228; *see also* Carl Deal & Joanne Doroshow, *Corporate Astroturf and Civil Justice: The Corporations Behind “Citizens Against Lawsuit Abuse”*, MULTINAT’L MONITOR, Mar. 2003, at 18.
- 152 Compare CTR. FOR RESPONSIVE POL., *Top Industries, Republican Party (2004 Election Cycle)*, at <http://www.crp.org/parties/indus.asp?Cmte=RPC&Cycle=2004>, with *Top Industries, Democratic Party (2004 Election Cycle)*, at <http://www.crp.org/parties/indus.asp?Cmte=DPC&cycle=2004>; *see also* Milbank, *supra* note 150 (citing the Center for Responsive Politics’s reports on political

contributions during the first half of Bush's first term as president, noting that "health care professionals and insurers have given two-thirds of their \$71 million in contributions to Republicans").

153 George Silver, *Health Care: Beyond Markets*, WASH. POST, Nov. 11, 2004.

154 U.S. CONG. OFFICE OF TECH. ASSESSMENT, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE 16 (OTA-H-602, July 1994), *available at* <http://www.wws.princeton.edu/cgi-bin/byteserv.prl/~ota/disk1/1994/9405/9405.PDF>.

### ***About the Center for Progressive Reform***

Founded in 2002, the Center for Progressive Reform is a nonprofit research and educational organization of accomplished university-affiliated academics with expertise in the legal, economic, and scientific issues related to protecting health, safety, and the environment from dangerous pollutants, harmful products, and other hazards. CPR believes sensible safeguards in these areas serve important shared values, including doing the best we can to prevent harm to people and the environment, the fair distribution of environmental harms and amenities, and protecting the earth for future generations. CPR therefore rejects the conservative view that the economic efficiency of private markets should be the only value used to guide government action. CPR supports government action and ready public access to the courts to protect consumers, public health and safety, and the environment. CPR prepares studies, reports, articles, and other analyses that promote informed and effective public policy, and government decision-making processes that encourage and value citizen input. Direct media inquiries to Matthew Freeman at [mfreeman@progressivereform.org](mailto:mfreeman@progressivereform.org). For general information, send email to [info@progressivereform.org](mailto:info@progressivereform.org). Visit CPR's website at [www.progressivereform.org](http://www.progressivereform.org). The Center for Progressive Reform is grateful to the Deer Creek Foundation for its generous support of this project and CPR's work in general.



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