

The Economics of Medical Malpractice

Jeff Graw

On February 27, 2003, American Medical Association (AMA) President-elect Donald Palmisano called on the U.S. Congress to bring “reasonable reforms to our broken medical liability system.” The costs of medical liability insurance and defending against lawsuits are at issue. His plan calls for unlimited economic damages (medical bills, lost wages, expenses), with a cap of \$250,000 on noneconomic damages (pain and suffering), and limits on attorney fees to maximize recovery for the patient. Referring to laws in California, he states that “these reforms are not part of some untested theory. They work.”¹

On the surface, Palmisano’s plan sounds reasonable. However, his argument contains serious flaws, and for many malpractice victims, his plan does not work. Based on personal experience, I will argue that the AMA focuses too much on financial issues, while neglecting how it might minimize medical mistakes. Current laws buffer the medical industry from responsibility for mistakes. Furthermore, the idea that medical institutions should receive substantial payments for fixing these mistakes essentially rewards errors, and creates an environment of disincentives for improvement. In short, the AMA’s proposal, along with many laws such as those in place in California and Colorado, has worked to further victimize the victims of malpractice, and create an environment in which errors are perpetuated.

In my experience, legislators are generally uninformed of the impact of laws on malpractice victims. The common opinion is that legitimate victims of malpractice are

treated fairly, and that doctors are subject to frivolous lawsuits. Our legislators are being told that even more laws need to be passed to protect doctors from these lawsuits. I would like to counter the arguments of the AMA and the insurance lobby from a victim's perspective.

Our Story

I became interested in this subject last year when my wife Tanya almost died from some mistakes made in a medical procedure. She went into the hospital for a minor outpatient procedure, and was only supposed to be in the hospital for a couple of hours. Two hours ultimately became two full weeks in the hospital, with three additional weeks of recovery at home. She required two surgeries to fix the injuries she received in the initial procedure, and the hospital took about \$15,000 from the health insurance system to fix the injuries. This was more than just a five-week disruption of our lives. I will spare you the details of two weeks of stomach pumps, catheters, and IVs that made her hands swell like balloons, or her tearful expression of fear just before they took her off to the second surgery. She is now disfigured: the surgical scars go from pubic bone to navel. The larger one did not heal well, and so her natural curve is replaced with ripples and a deep concavity at the center of the incision. From the injuries she received, she now has a future risk of intestinal complications, and she has scarring in her uterus. We now face a complicated pregnancy, and are obligated to have a c-section if she has a baby. Tanya had a small, protruding (pedunculated) fibroid on the inner wall of her uterus; the two common treatment options are electrical dissection with a resectoscope, and embolization.² We were very concerned in the pre-surgery meeting, when the doctor told

us that his technique was to pinch, and then pull off, or basically tear off, the fibroid with a pair of forceps; he said he had never used a resectoscope. I was ready to leave and find another doctor. Recognizing this, he asserted that the procedure was “simple,” and the risks were “rare,” and he talked us into proceeding. During the procedure, the doctor punctured her uterus and small intestine. The procedure was then upgraded to major surgery, where he sewed her uterus back together, but missed the puncture in the intestine. After the surgery, he said he did not know what happened. I asked him what besides the uterus had been punctured, and he said he checked the intestine but found nothing.³ She was released from the hospital the next day. We returned to the hospital after she became very sick. After several days of testing, it was determined that a second “exploratory” surgery was needed, where the hole in the intestine was found.

Puncturing the uterus and intestine is not considered malpractice, since they are known risks, and we were informed of these risks. However, when a doctor does not treat an injury that he causes, it is malpractice. The original doctor assisted in the second surgery, and the two doctors emerged from surgery with the following explanation regarding the hole in Tanya’s intestine; please read it carefully:

The fresh wound on the uterus stuck to the small intestine. The uterus then pulled on the intestine and tore a hole in it. This occurred after the patient was released from the hospital, so the doctor was not responsible for the hole. Interestingly, there was no further damage to the freshly injured uterus after pulling on the intestine. Additionally, there were no pieces of intestine stuck to the uterus after the uterus “tore” the hole in the intestine. The hole in the intestine then stuck itself to the colon, which is where the second surgeon found it.

At the point of the second surgery, I was not thinking about a lawsuit; I was just wondering whether Tanya would ever come home alive. The first doctor talked me into a procedure that I was uncomfortable with, and Tanya nearly died. I was feeling guilty and very angry, and wanted a better explanation than “I don’t know what went wrong.” The given explanation sounded like nothing more than a lie to cover the doctor’s blunder, and protect him from liability. So I asked the hospital to investigate. Without asking us any questions, the hospital informed us the following month that their investigation was complete, and neither the doctors nor the hospital had made any mistakes, these were just “surgical complications.” When I protested that their investigation was ridiculous, they said they would re-open it, but the results would be confidential. Given the hospital’s unresponsiveness, I then asked the doctor’s direct employer to investigate. They never responded. We needed the assurance that the doctor’s mistakes would be investigated thoroughly so that it did not happen to anyone else. Instead, we felt that the matter was being swept under the rug. Our biggest concern was that all investigative objectivity was lost in the attempt to protect the doctor. At this point, we started talking to the lawyers. We were not interested in getting money; this was the worst experience of our lives, and we wanted a serious review of the procedure, and for this event to be appropriately reflected in the doctor’s record. We got neither; instead, we found out that cases like ours do not go to court in Colorado.

Were the AMA’s Figures Correct?

One would expect a speech delivered by a group of highly respected, well-educated people to the U.S. Congress to be thoroughly researched; the writer should fully

understand the nature of any data presented. Yet the AMA's presentation to Congress is full of errors. In his address, Palmisano claims that many physicians have been hit with premium increases from 25 to 400 percent, and that the average jury award for malpractice claims is now \$3.5 million.⁴ This jury award figure came from Jury Verdict Research (JVR), a private research firm. JVR maintains a cumulative database of over 193,000 plaintiff and defense verdicts, which is used by attorneys in predicting malpractice trends.⁵ Because the data is self-reported, it tends to represent extreme cases. For instance, malpractice attorneys are likely to report low defense verdicts, demonstrating how the courts favor business. Likewise, insurance attorneys report high-dollar plaintiff awards. Because of this, JVR is not a good source for average statistics. The National Practitioner Databank (NPDB) provides a better indicator of actual payments. The NPDB, mandated by Congress in 1990 and maintained by the Department of Health and Human Services, requires that malpractice insurers report payments on all malpractice cases. Because the reports are on actual payments, rather than jury awards, it accounts for the fact that jury awards are often reduced on appeal; it also includes cases that were settled out of court, and therefore reflects the actual financial impact of malpractice cases. NPDB's 2001 Annual Report shows a national average payment of \$270,854, and a median payment of \$135,000.⁶ Palmisano's award figure is thus incorrect by about a factor of eight.⁷

Quoting JVR, Palmisano claims that between 1999 and 2000 the median jury award increased by 43%, and "more than half of *all* jury awards today top \$1 million."⁸ Again, these figures are true only for the cases reported to JVR, not for *all* cases in general. NPDB shows a total payment increase of 27.6% from 1999 to 2000, and 8.8%

from 2000 to 2001.⁹ The average payments were \$195,093 in 1999, \$248,947 in 2000, and \$270,854 in 2001—all far short of the award figures quoted by Palmisano.¹⁰ If Palmisano had a strong argument, he would not need to use exaggerated figures, nor anecdotal claims like 400% increases in insurance premiums: how many doctors received these increases, and were their records clean? There are two logical conclusions, both of which are disturbing—either the AMA is deliberately trying to mislead Congress and the public, or they have no concept of the true scope of the problem.

Undermining Patients' Rights

Not only are Palmisano's figures inaccurate, there are also serious flaws in the logic of his arguments. He states that his reforms could result in a "\$50 billion reduction in national health spending"¹¹ through reduced payouts, court costs, and "defensive medicine"—defined by the AMA as ordering unnecessary tests and making unnecessary referrals in order to avoid possible litigation. According to the NPDB, less than \$4 billion was paid in 2001 for all malpractice payments. If court costs are roughly 75% of payments,¹² then \$42 billion of Palmisano's estimated figure is spent on defensive medicine. If I understand Palmisano correctly, doctors are more concerned about their liability than they are about their patients' health: his statement suggests that there are \$42 billion worth of cases in which doctors would be willing to assume an increased health risk for the patient, but are not willing to assume an increased financial risk for themselves. Consider the following fictitious example to illustrate the point. Suppose it is known that 1% of all chronic headache cases result from brain tumors. A competent doctor will not order tests for a condition the patient cannot have: doctors do not give

pregnancy tests to men. So if a test is given, it has already been established that the bad thing we are testing for *could* happen given the patient's condition. According to my understanding of Palmisano's argument, a doctor seeing headache patients might rationalize that 99% of the MRI tests he prescribes are unnecessary, and the only reason that he gives the test is to avoid possible litigation if he misdiagnoses the one bad patient. The study quoted by Palmisano reports that 79% of doctors admit to giving tests to avoid possible litigation.¹³ If his plan is implemented as proposed, then it is logical to assume that some serious health problems that are currently being diagnosed will now be missed because of reduced "unnecessary" testing. This leads to an important question: if the risks are high enough to be concerned about liability, why are they not high enough to be concerned about the patient's health?

In reality, good doctors will continue to give tests for risks they consider significant. What Palmisano is trying to achieve, but trying not to say, is freedom from responsibility for not performing a life-saving test. The real issue is malpractice costs; Palmisano's presentation was titled "liability reform," not "reduced healthcare spending." The \$42 billion in "savings" is just an excuse to attack the \$8 billion in malpractice costs. If saving money was the primary concern, the AMA's plan should also address the high cost of fixing injuries caused by medical mistakes, which costs consumers about \$12 billion annually.¹⁴ A law making hospitals, rather than patients, financially responsible for their doctors' mistakes would create economic incentives ensuring that doctors are trained in the latest, lowest-risk procedures.

Palmisano's proposed plan makes it sound as if victims of malpractice will be treated fairly, and the cap will just prevent frivolous lawsuits. However, consider what

this cap has done in Colorado. A well-publicized Harvard study claims that medical mistakes result in 98,000 deaths per year; a National Academy of Sciences study puts the figure at 44,000.¹⁵ Medical researcher Rod Hayward disputes both studies and claims that the number is “between 5,000 and 15,000...But...those numbers are rough estimates.”¹⁶ His research was based on a study involving 179 deaths at veteran’s hospitals, and was published in *JAMA*, the Journal of the American Medical Association. If we give him the benefit of the doubt, and use the figure of 10,000 deaths per year, then statistically there are approximately 154 mistake-related deaths per year in Colorado.¹⁷ In 2001, a total of 134 medical malpractice payments were made, leading to the conclusion that there are fewer malpractice awards than there are deaths from medical mistakes in Colorado. Personal experience substantiates this; as a result of the near-death of my wife, I spoke to over 25 malpractice attorneys in the Denver area. They all stated their primary focus as death and disability cases. Access to court is effectively barred for us, as with most cases not resulting in death or disability. Additionally, if my assertion of “fewer awards than deaths” is correct, then there should also be cases of medical negligence, resulting in death, whose survivors receive no compensation. We did not have to go far to find a case that likely fits this category: our veterinarian’s sister went into a Denver hospital last year with abdominal pain, and was admitted. A blood test showed a high white cell count, indicating infection. She received no treatment for several hours until she went into cardiac arrest. At this point she was finally given antibiotics, but it was too late and she died. It was later discovered that she had peritonitis. This case is not attractive to attorneys because it cannot be proved that she would have lived, even with prompt treatment. The burden of proof is on the plaintiff, and 80% of verdicts go to the defense

in Colorado. Despite the lack of prompt medical treatment, the hospital promptly billed the woman's health insurance for over \$20,000. Our vet pointed out that a cat with that level of white count would have received immediate and constant attention at their animal hospital.

The number of deaths/disabilities/injuries caused by medical mistakes is not tracked or published, so there is no accurate count of these cases. Statistically, disabilities and injuries should exceed the number of deaths. According to the NPDB, a total of 16,700 malpractice payments were made nationally in 2001. This number is only slightly larger than the deaths figure published by the AMA. Now compare the 16,700 payments with the statistics for one common procedure: gall bladder surgery. There are at least 24,000 injuries and deaths per year from this procedure.¹⁸ More people are hurt or killed by this one procedure alone than the entire number of malpractice payments made.

I am uncomfortable talking about malpractice lawsuits in terms of compensation, for what is the "fair" value of someone's life? We have already established that the vast majority of cases settled in this state are for death and disability. These people's lives were worth an average of \$257,285 (not even close to \$3.5 million) in 2001. This means that if you or a loved one are killed or disabled from a medical mistake in Colorado, you might receive \$257,285 minus the entire medical bill¹⁹ and the 30% attorney's fee.²⁰ If the injury was permanent, but did not result in disability, you can expect to receive nothing. Initially, this may sound hard to believe, but this is what the numbers show. Palmisano claims if it were not for malpractice attorneys, people would be treated fairly.²¹ However, we had no attorney to represent us because our case was not economically viable to take to court. Our take-it-or-leave-it settlement from COPIC

(before taxes²²) was \$3500 (79% of our lost wages), and \$1250 for our co-payments on all the extra medical bills. Palmisano is not being honest or fair regarding the treatment of malpractice victims. Even in the most egregious cases involving gross negligence, the industry will often force families to endure costly and lengthy court battles instead of settling swiftly and fairly. He also complains about the cost of defending malpractice cases; meanwhile malpractice insurance companies usually require the plaintiff's attorney to obtain expert witnesses and incur all the expenses of trial preparation before offering an out-of-court settlement. As we found out from personal experience, without an attorney, there is no offer of fair compensation for injury.

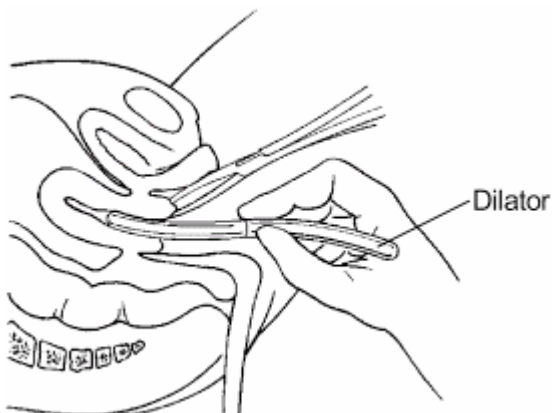
That the medical industry was not concerned about our interests can be seen in the superficial investigation we received, and a settlement that did not even cover our basic losses. Limiting attorneys' fees was sold to our legislators as *maximizing recovery for the patients*. Is this a joke? Evaluate his plan using basic economics: limiting attorney's fees will decrease their supply of labor, thus reducing the number of malpractice cases, and leaving malpractice victims to the charity of the insurance industry. This will simply maximize recovery for the doctors, and leave victims with nothing, or partial recovery of losses at best. Palmisano's plan serves the medical industry, not the public, as does the "benefit" of receiving help paying the extra hospital bills for fixing the injuries caused by mistakes.

It seems reasonable that if there is no accountability for mistakes, and no economic pressure to improve high-risk procedures, then these reforms will actually serve to increase healthcare costs, and reduce the quality of healthcare. What business would spend money to prevent errors if its errors came with large financial rewards and

no risks? It is a matter of basic economics to assume that many preventable medical mistakes will continue to occur until a time when these mistakes are no longer economically profitable. Medical malpractice will continue to be an issue until the time when medical institutions are made financially responsible, and the free-market pressure is allowed to occur.

Are “Complications” Inevitable? A Case Study

The medical industry promotes the idea that the human body and medical procedures are very complicated, and that a certain number of complications are inevitable. I decided to test this theory. The doctor suggested that Tanya’s injury might have occurred during cervical dilation. I researched this procedure, and want to evaluate it from an engineering perspective. A nonmedical evaluation is valid, since I am an engineer, and engineers design medical equipment. Much of my information on the procedure comes from a document written by Dr. John Petrozza; he describes the procedure as “challenging.”²³ The cervix is located at the bottom of the vagina, approximately six inches inside the body. The procedure for dilating the cervix is to grasp the cervix with a tenaculum or ringed forceps, and to push successively larger dilators through the cervical aperture until it is dilated to the desired size.²⁴ Petrozza recommends



using a double-toothed tenaculum or the many-toothed forceps, because the single-toothed tenaculum tends to slip.

Mechanically, the procedure is to use the opposing forces of simultaneously pushing

and pulling to force the aperture open. He states that the two most common injuries associated with this procedure are cervical trauma and uterine perforation. The tenaculum or forceps can cause lacerations or tearing of the cervix. The more dangerous complication, however, is uterine perforation. The process of dilator insertion involves blind entry into the uterine cavity. If the uterus is folded forward or back, or if the doctor pushes too far, the uterus can be ruptured. Petrozza recommends the use of ultrasound to “aid in direction of dilation,” although it is not clear that many facilities used ultrasound as part of the procedure.²⁵ Associated with uterine perforation is collateral damage to nearby organs such as the bladder or intestines. The known rate of uterine perforation is approximately 0.75%. While the injury rate may be small, tens of thousands of women have the procedure done every year, and some of them die from the complications. This is the only procedure used in dilating the cervix beyond 6mm—required for most transcervical procedures.

There are no liability issues for injuries associated with this procedure. Since this procedure is the “standard of care,” and patients are informed of the potential complications, the risks belong entirely to the patient. Additionally, since the complication rate is “rare,” there is little pressure to improve the procedure. An engineering perspective suggests that a short, radially-expanding instrument would eliminate most of these injuries. I found several “balloon” dilators on the web that could serve this function.²⁶ The problem is that even if the balloon dilator was available, doctors are still free to use the instrument of their choice. Older doctors operate under a type of grandfather-clause that allows them to continue to use procedures that were taught when they went to school, even if these procedures are outdated, carry higher

risks, and are no longer even taught in medical schools—all without the danger of being outside the standard of care, or incurring liability. Laws intended to corral greedy lawyers have instead worked to stifle innovation, and create a system where mistakes continue.

Another problem arises when health insurance companies push doctors into using newer, cheaper procedures for which they have not been properly trained. Laparoscopic surgery is a perfect example of this. The industry is currently experiencing many laparoscopy-related injuries as doctors train on the job. Even when doctors become experts in this surgery, there is still an injury rate that approaches 1%.²⁷ Robotic laparoscopy has the potential of greatly reducing the incidence of these injuries. Doctors who are training on the use of this equipment could do so under the supervision of an expert thousands of miles away. Additionally, the laparoscope would be under the guidance of a control-system, rather than directly under the control of a comparatively shaky hand. Sensors on the scope head could sense when the scope is being pushed into an internal organ, and prevent the organ from being punctured. There are upwards of a dozen starving engineering firms working on the problem right now. Instead of spending \$15 million manipulating our lawmakers by lobbying for liability reform,²⁸ perhaps the AMA could find some money to help support this effort. Widespread acceptance of this technology may require some outside pressure. Investing in technology that prevents mistakes costs money, but fixing the injuries caused by mistakes profits the medical industry with more money than Bill Gates makes.

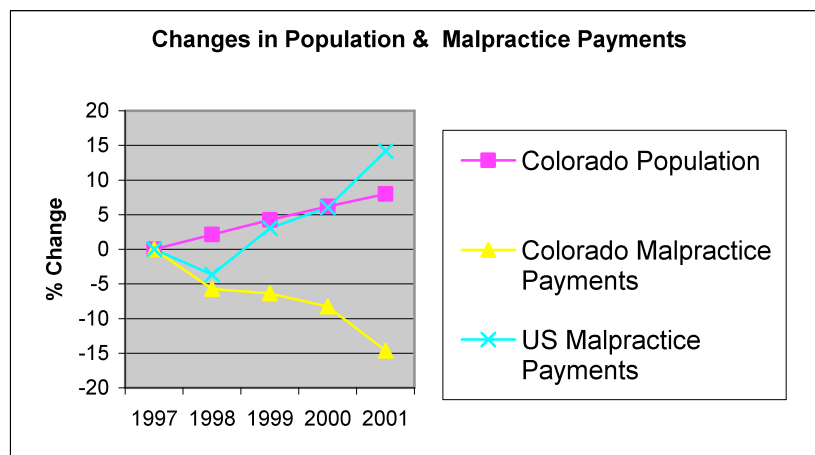
Colorado's Failed Tort Reforms

I stated in my introduction that our legislators are generally uninformed about the impact that their laws have had on malpractice victims. Allow me to elaborate.

Palmisano's plan masks a devious reality. If the insurance industry proposed a bill limiting malpractice lawsuits to just death and disability cases, the bill would never become law. But, in effect, malpractice lawsuits *are* limited to death and disability cases when laws placing caps on noneconomic damages are combined with other seemingly unrelated laws. Examples are the right-to-subrogation law, and the requirement of expert testimony in all court cases. These laws effectively combine to deny access to court for an entire class of malpractice cases because these cases are no longer economically viable to take to court. For example, the right to subrogation law sounds reasonable when considered as an isolated law: why should the patient's health insurance company pay for the medical bills if there was malpractice involved? The intent of this law was to have the doctor's malpractice insurance pay the bills, and thus lower overall health insurance costs. However, malpractice victims tend to have higher medical bills (all the extra bills for patching them up). For many such cases, the combined court costs and medical bills exceed the potential jury award or the award cap. The net result is that neither the medical insurance company nor the victim is compensated for losses. This law, originally proposed to lower health insurance costs, has instead further skewed the system against malpractice victims, benefited doctors, and benefited the malpractice insurance industry through a reduction in the number of malpractice cases.

The NPDB ranks Colorado 47th compared with the other states in terms of malpractice payments.²⁹ If we compare the AMA published figures against NPDB

payment figures, we realize that Colorado malpractice insurance does not even pay to bury all the people our doctors kill. Doctors in Colorado pay an average of \$9,400 per year for malpractice insurance,³⁰ compared with the hundreds of thousands of dollars that Palmisano claims doctors in other states pay. Over the five-year period from 1997 to 2001, the number of malpractice payments in the U.S. has risen almost 15%, and the



population in Colorado has increased by about 8%. During this same period, the number of malpractice cases in Colorado has decreased by 15%. This reduction is not the result of reduced error rates; it is the result of aggressive political lobbying. With the number of litigation cases and overall malpractice costs being so low,³¹ you might think that there would be no further discussion about reducing malpractice costs. To the contrary, lobbyists have launched a full-scale attack on malpractice victims in this legislative term. Despite the fact that the Colorado Medical Society acknowledges Colorado as “one of the...best tort reform situations in the country,”³² Bush Administration appointees at the Department of Health and Human Services³³ have just listed Colorado as one of the “new states in crisis.”³⁴ It is ironic that in Palmisano’s presentation to Congress, he referenced

Colorado, one of the lowest payout states in the country, as one of the states in crisis and needing the national medical liability reform.

Leading the fight for further reforms is Republican State Representative Tambor Williams of Greeley. She sponsored Colorado House Bills HB1007, HB1012, and HB1060. HB1060 proposes to limit lawyers' fees to 20% of the malpractice award. We should not assume that a 33% to 50% reduction in lawyers' fees will result in a linear reduction in the number of malpractice cases. There will be some "critical mass" point at which most lawyers will simply stop taking malpractice cases. With only 134 malpractice payments made in the state for 2001, there is not much left to cut. At the heart of Williams's argument is the claim that high malpractice costs are putting rural doctors out of business.³⁵ It seems reasonable to me that a special provision could be written into the malpractice insurance policy for rural doctors who handle a small number of patients. The doctor's insurance rate could be prorated, based on the number of patients taken. But this issue is not about rural doctors; they are just the excuse. It is more likely about eliminating the few remaining malpractice payments in Colorado.

A Different Approach

The critical concern is not that people who are injured or killed are not being reasonably compensated. The reality is that if all the people who are injured by medical mistakes were so compensated, it would bankrupt the medical system. Ridiculous? If I am wrong, then there should be no opposition to a law that lists all potential injuries, places reasonable compensation values on the injuries, and then automatically and promptly pays these victims when these injuries occur—no courts, no lawyers.

Reasonable compensation is not *partial recovery* of lost wages. But for anyone who could be silly enough to say that we are just angry because we did not get money out of this, how much money is risking your life worth? We are not asking for compensation. A system that compensates victims, but allows mistakes to continue, is not the solution. Palmisano asked Congress to bring common sense back to our broken medical liability system. That's fair. But I would like to add that we need to bring back common sense to our broken medical system as well. Addressing this is well beyond the scope of a short paper, but we could start with one simple step: almost killing someone is not a *complication*; it is a *mistake*. Admitting you have a problem is the first step toward the solution.

Notes

1. AMA press release, 27 Feb. 2003. 11 Sept. 2003 <<http://www.ama-assn.org/ama/pub/print/article/1616-7261.html>>.
2. Nonsurgical technique that involves blocking the blood supply to the fibroid. Moderate successes have also been achieved with drug treatments. There are newer experimental techniques, such as laser treatment and the sonic knife, which are still under development and not widely available.
3. Although the doctor said he did not know what happened, he did offer the known risks as possibilities: injury occurred while dilating the cervix, maybe he pushed the scope through her uterus, or he cut through the uterus during the D&C. He did not offer the possibility that the injury came as the result of (1) simultaneously manipulating forceps

and scope, or (2) cauterization of the freshly torn area. Note that in the doctor's three scenarios of cutting or puncturing the uterus, he claims he did not injure the intestine immediately behind the punctured area on the uterus.

4. AMA press release, 10 Feb. 2003, 11 Sept. 2003 <<http://www.ama-assn.org/ama/pub/print/article/1616-7326.html>>.

5. JVR online summary does not contain the \$3.5 million average award figure, but rather the \$1.0 million median award figure. The full report contains the average figure, and is available from JVR: 11 Sept. 2003.

<http://www.juryverdictresearch.com/Press_Room/Press_releases/medmal_01/medmal_01.html>.

6. U.S. Department of Health and Human Services [USDHHS], *National Practitioner Databank, 2001 Annual Report*, p. 49, Table 9, 11 Sept. 2003

<<http://www.npdb-hipdb.com/pubs/stats>>.

7. To get a good approximation of the real 2001 award figure, we need to take into account the fact that malpractice victims are forced to wait from 3 to 6 years for payment; so we will not know the average 2001 payment for about another 4 years. If we assume that the \$270,854 figure is from awards given an average of 4.5 years ago, then in order for Palmisano's figure of \$3.5 million to be correct, there needed to be an average payment increase of 75% per year over the past 4.5 years. Nothing close to a 75% annual increase has actually happened. Comparing the NPDB reports from 1996 to 2001, the actual payments increase has been approximately 8% per year. If we assume a 10% increase per year, the average 2001 payment will likely be somewhere around \$435,000—not \$3.5 million. Palmisano's figure is wrong by a factor of 8.

8. AMA Press Release, 10 Feb. 2003, p. 2. Interestingly, the alarming trend did not continue into 2001. JVR reported a 0% increase in the award figure from 2000 to 2001. <http://www.juryverdictresearch.com/Press_Room/Press_releases/Verdict_study/verdict_study2.html>. Again, the actual payments increased at a rate of about 10% per year from 1997 to 2001.
9. USDHHS 47, Table 7.
10. USDHHS, *National Practitioner Databank, 1999 Annual Report*, 11 Sept. 2003 <<http://www.npdb-hipdb.com/pubs/stats>>, n.p., Table 11; *National Practitioner Databank, 2001 Annual Report*, p. 49, Table 9.
11. AMA press release, 10 Feb 2003.
12. According to COPIC, Colorado's largest malpractice insurer, their cumulative total operating costs are \$180.3 million over the company's 17-year history (2001 report), compared with total malpractice payments of \$238.8 million (costs are 75.5% of payments). 2 Oct. 2002, 11 Sept. 2003 <http://www.callcopic.com/cic/financials/2001_financial_highlights.htm>.
13. "Harris Interactive's Fear of Litigation Study: Executive Summary," Common Good 2002, 13 Sept. 2003 <http://ourcommongood.com/medicine/item?item_id=3396>.
14. Institute of Medicine, *To Err is Human; Building a Safer Health System*, by Linda T. Kohn, Janet Corrigan, and Molla S. Donaldson, National Academies Press, 2000, 1-2 <<http://books.nap.edu/books/0309068371/html/1.html#pagetop>; <http://books.nap.edu/books/0309068371/html/2.html#pagetop>> Medical error costs are estimated between \$17 billion and \$29 billion, over half of which are healthcare costs. My figure: $(17+29)/4 = \$11.5$ billion.

15. “Preventing Death and Injury from Medical Errors Requires Dramatic, System-Wide Changes,” *National Academies News*, 29 Nov. 1999, 13 Sept. 2003

<<http://www4.nationalacademies.org/news.nsf/isbn/0309068371>>.

16. “Study: Estimates of Medical Errors are Overblown,” *USA Today*, 24 July 2001, 13 Sept. 2003 <<http://www.usatoday.com/news/health/2001-07-24-medical-errors.htm>>.

17. Colorado has 1/65th of the US population, giving $10,000/65=154$ deaths per year.

18. There are between 600,000 and 700,000 gall bladder operations (cholecystectomy) each year, according to the National Institutes of Health (“State-of-the-Science Conference Statement, 10 June 2002, 13 Sept. 2003

http://consensus.nih.gov/ta/020/020sos_statement.htm). The Web Health Center reports

that roughly 60% of these operations are done laparoscopically, for a total of 360,000 procedures, leaving 240,000 open cholecystectomies (WebHealthCentre.com,

“Gallstones,” 2000, 13 Sept. 2003

<<http://www.webhealthcentre.com/surgcor/patient.asp>>). A study reported in *American*

Family Physician found a complication rate of 5.8% and mortality rate of 0.23% for

laparoscopic cholecystectomy; thus the laparoscopic procedure results in $360,000 \times 6\% = 21,600$ injuries/deaths (Anne D. Walling, M.D., “Follow-Up after Bile-Duct

Sphincterotomy,” *American Family Physician* 15 Jan. 2003, 13 Sept. 2003

<<http://www.aafp.org/afp/20030115/tips/21.html>>). Dr. David Anaise, an expert in

cholecystectomy injuries, provides the rate of one particular complication during open

cholecystectomy of approximately 1%, resulting in $240,000 \times 1\% = 2,400$ complications.

(David Anaise, M.D., “Laparoscopic Surgery a Primer for the Lawyer,” 13 Sept. 2003

<<http://www.danaise.com/laparoscopy.html>>). While we can assume that other types of

complications occur during the open procedure, complication rates are very hard to find.

19. The Right-to-Subrogation law reimburses the health insurance company from the victim's award.

20. Palmisano's plan is to limit attorneys' fees in order to maximize recovery for the patient. Compare the above result with my wife's direct settlement from COPIC, a settlement she made without being able to obtain an attorney.

21. AMA Press Release, 10 Feb. 2003, page 7.

22. Court settlements are usually not taxable. Because this was a voluntary "gift" from COPIC, rather than an enforced legal settlement, the IRS taxed this as income.

23. John Petrozza, M.D, "Hysteroscopy," *emedicine*. 1 July 2002, 14 Sept. 2003
<<http://www.emedicine.com/med/topic3314.htm>>.

24. World Health Organization, "Managing Complications in Pregnancy and Childbirth—A Guide for Midwives and Doctors," 14 Sept. 2003
<http://www.who.int/reproductive-health/impac/Procedures/Dilatation_P61_P63.html#P62%20fig%2032>.

25. Pretrozza, "Hysteroscopy."

26. See, for example, the inflatable catheter for dilating the cervix being developed by Yozmot HaEmek Technological Incubator, 14 Sept. 2003
<<http://www.matimop.org.il/newrdinf/company/c5243.htm>>.

27. Anne D. Walling, M.D., "Risk of Complications During Gynecologic Laparoscopy," *American Academy of Family Physicians*, 1 Nov. 1999, 14 Sept. 2003
<<http://www.aafp.org/afp/991101ap/tips/20.html>>.

28. Center for Justice and Democracy, *A Short Guide to Understanding Today's Medical*

Malpractice Insurance "Crisis" (and Useful Questions to Ask), 25 Sept. 2002, 14 Sept. 2003 <<http://www.centerjd.org/MediaGuide.pdf>>, p. 5.

29. U.S. Department of Health and Human Services [USDHHS], *National Practitioner Databank, 2001 Annual Report*, p. 49, Table 9.

30. COPIC annual financial statement, 2002, p. 5: premiums collected \$56,212,786.

COPIC insures approximately 6000 doctors. Of course, some doctors will pay more than others, but \$9,400 is the average.

31. To put actual numbers on this, COPIC paid \$24.8 million in malpractice claims in 2002. Since COPIC insures 75% of the doctors in Colorado, we are talking about approximately \$33 million. Expanding this figure to a national scale, if Colorado's malpractice system was used nationally, the \$4 billion in malpractice payments paid nationally would drop to \$2.2 billion.

32. Amy Fletcher, "Bills Stir Up Debate on Limiting Medical Malpractice Payments," *Denver Business Journal*, 3 Feb. 2003, 14 Sept. 2003

<<http://denver.bizjournals.com/denver/stories/2003/02/03/story3.html>>.

33. "Bush Administration Grandstanding on Medical Malpractice, Failing Patients in Need of Better Medical Care," *Public Citizen*, 2002, 14 Sept. 2003

<<http://www.citizen.org/congress/civjus/medmal/articles.cfm?ID=8100>>; Fletcher.

35. "Medical Malpractice Contingency Fees," Colorado Civil Justice League, 14 Sept. 2003 <<http://www.ccjl.org/initiative4.cfm>>.

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