H.R. 5 - the Protecting Access to Healthcare (PATH) Act - the Health Care Industry's Latest Attempt to Avoid the Financial Consequences of Epidemic Levels of Malpractice

On Thursday, March 22, 2012, the House of Representatives passed H.R. 5, the Protecting Access to Healthcare (PATH) Act, a bill originally introduced by Representative Phil Gingrey (R-GA), which if passed into law will cap all pain and suffering awards in medical malpractice cases at $250,000. H.R. 5 also reduces the amount of attorneys fees that can be paid to a lawyer who represents a victim of malpractice. Of course, defendant health care providers still have a right to pay lawyers they employ to defend these cases any amount they wish. The bill also seeks to impose draconian restrictions on patients' rights of redress against drug companies and medical products manufacturers who profit off of dangerous or misleading products in the marketplace.

The rationale for the proposed medical malpractice restrictions according to the sponsors of the bill is that jury trials in medical malpractice cases are "a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients." Additionally, the authors of the Bill contend that the threat of a lawsuit "is a deterrent to the sharing of information among healthcare professionals which impedes efforts to improve patient safety and the quality of care." Among the stated goals of H.R. 5 is to "reduce the incidence of defensive medicine and lower the cost of health care liability insurance."

It is impossible to argue that a one-size-fits-all pain and suffering award of $250,000 is a just way to make a victim of medical malpractice whole after he suffers tragic debilitating injuries. Under the circumstances, Representative Gingrey (a retired obstetrician who has been sued for malpractice three times) has taken a page out of Orwell's 1984, and H.R. 5 is drafted as if came straight from the Ministry of Truth. The bill is said to be designed "to ensure that persons with meritorious health care injury claims receive fair and adequate compensation." In actuality, H.R. 5 takes away a medical malpractice victim's ability to have a jury of his peers decide what a fair measure of compensation is. Representative Gingrey contends that H.R. 5 will benefit victims of medical malpractice "by reducing uncertainty in the amount of compensation provided to injured individuals." The only time that the $250,000 cap on damages will result in certainty, however, is when it limits a jury award that would have otherwise been higher. Somewhat ironically, the New York Times recently reported that the $250,000 cap is half of what Representative Gingrey settled his last medical malpractice litigation for, after he was accused of providing negligent care to a pregnant woman.

Tort reform advocates have been attempting to shift the burden of medical mistakes from the health care industry to victims of negligence for years. The argument is cloaked in self-righteousness: Victims' rights have to be curbed, and after this occurs, physicians will no longer be afraid to disclose errors. This will cause a change in the culture of medicine and allow medical errors to be analyzed and approached in a new more comprehensive way. Unfortunately, medical literature published by doctors (not lawyers) and the recent history of the patient safety movement provide plenty of reasons to be skeptical of this trickle-down approach to safety.

H.R. 5 will drastically restrict innocent victims' rights of redress in medical malpractice cases, while rewarding the health care profession with immunity for its failure to police itself. This is not only incredibly irrational from a public policy standpoint, it is also immoral because for the last ten years, an epidemic medical malpractice problem in the United States has resulted in hundreds of thousands of unnecessary deaths, and despite this, advances in patient safety have stalled and error rates have held steady.

In November 1999, the Institute of Medicine, a branch of the National Academy of Sciences, published a study declaring that a threshold improvement in the quality of health care was urgently needed because medical negligence committed in hospitals in the United States was killing more people annually than motor vehicle accidents, breast cancer and AIDS. Kohn LT, et al, To Err Is Human: Building a Safer Health System, National Academy Press pg. 26 (1999). The impact of that study, and its "jarring" analogy that the annual number of deaths from hospital negligence would be equal to the downing of a jumbo jet every single day, "galvanized the public and health professionals and led to congressional hearings, media exposes, and millions of anxious patients." Robert M. Wachter, M.D. , The End of the Beginning: Patient Safety Five Years After 'To Err Is Human," W4 Health Aff (Millwood) Web Exclusives 534 (2004).

Twelve years ago, To Err Is Human announced that the health care industry was "a decade or more behind other high-risk industries in its attention to ensuring basic safety." To Err Is Human, supra, at 5. The report was so shocking in part because "silence surrounds" the issue of medical malpractice. Id. The goal of To Err Is Human was noble: to break the cycle of inaction in the health care industry. Id. at 3. Action was urged 10 years ago because doctors (not lawyers) finally declared that the status quo was not acceptable and could no longer be tolerated. To Err is Human argued that preventable errors could be reduced by designing safety into the health care delivery system. Id. To do that, a four tiered approach was advocated. The health care industry needed to undertake a national effort to create leadership, research, tools and protocols to enhance the knowledge base about safety; identify and learn from errors through immediate and strong mandatory reporting efforts, and voluntary reporting efforts, with the aim of making sure the system is made safer for patients; raise the standards and expectations for improvements in safety through the actions of oversight organizations, group purchasers, and professional groups; and create safety systems inside health care organizations through the implementation of safe practices at the delivery level. Id. at 6.

In To Err Is Human, the IOM called for a 50% reduction in medical errors in five years, but ten years later it was clear that progress in the area of patient safety was still far short of that goal. Lucian Leape, et al., Transforming Healthcare, a Safety Imperative, 18 Qual. Saf. Health Care 424 (2009). Indeed, one commentator observed that "[s]hockingly modest progress has been made given the impact of the problem, how many people were made aware of it and how many efforts have been made to address it." Howard Larkin, 10 Years, 5 Voices, I Challenge. To Err Is Human Jump-Started a Movement to Improve Patient Safety. How Far Have We Come? Where Do We Go From Here? 83 Hosp. Health Netw. 24a, 28t (2009). "The current status of hospital safety systems is not close to meeting IOM recommendations." Daniel R. Longo, OblSb, SeD, The Long Road to Patient Safety: A Status Report on Patient Safety Systems 294 JAMA 2858, 2858 (2005). Data from recent studies measuring safety progress suggests that "patient safety progress is slow, and cause for great concern." ld.

On Nov. 18, 2010, the New England Journal of Medicine published a study that attempted to quantify the impact of patient safety measures on in-patient hospital admissions. Christopher P. Landrigan, M.D. et al., Temporal Trends in Rates of Patient Harm Resulting from Medical Care, 363 New Eng. 1. Med. 2124 (2010). The authors specifically chose to evaluate the impact of patient safety efforts in North Carolina because that state showed a high level of engagement in efforts to improve patient safety. In spite of this, the study revealed that "harm resulting from medical care was common, with little evidence that the rate of harm had decreased substantially over a 6-year period ending in December 2007." ld. at 2130. The review revealed that 25.1% of the patients receiving medical care in the hospitals surveyed suffered from medically induced harm. Id. at 2124-2125. Sixty-three percent of these medical mistakes were entirely preventable. ld. at 21. More recently, in April 2011, a study appearing in Health Affairs suggested that medical errors occurring in hospitals are ten times more common than previously thought.

It is difficult to imagine the lack of results in the last twelve years in the patient safety movement being permitted to occur in any other industry. If ten years ago jumbo jets were falling from the sky every day and we learned from a study (conducted by the airline industry itself) that the resulting individual tragedies were avoidable if air carriers implemented policies and procedures in a systematic way to promote safe practices, citizens would demand change and there would be bipartisan support for government intervention to stop preventable deaths. The idea that thousands of deaths already occurred because of air carriers' failure to follow safety standards would be considered utterly scandalous. You certainly would not expect people to stand idly by while the planes continued to full from the sky every day for ten more years. If the planes did keep falling, nobody would dream of suggesting that we should reduce airline accountability to the victims who were dying because of preventable errors.

Given the last twelve-year history of the patient safety movement, it is irrational to suggest that providing more immunity to the health care industry will result in "an increased sharing of information in the health care system which will reduce unintended injury and improve patient care."

Advocates of tort reform hypothesize that the one of the reasons that medical malpractice is such a pervasive problem is that the health care industry is unable to examine errors in a systematic way because doctors are afraid to admit when they make mistakes for fear of being named as a defendant in a lawsuit. The theory is that if the financial consequences of medical mistakes are reduced, doctors will be more honest about admitting them, and this will lead to more data about errors, which will be analyzed and evaluated. Then, a "systems approach" will result in a safer health care sector.

The unsupported optimism that immunity will eventually result in a more honest approach to medical mistakes completely ignores the fact that physicians have always been required to be honest about medical mistakes, but have historically refused to act this way. Under the American Medical Association Code of Ethics, physicians have an ethical obligation to advise a patient when they commit consequential acts of medical malpractice when "a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment." Am. Med. Ass'n Code of Medical Ethics A-02 Edition, E-8.12 Patient Information, 77. Similarly, the American College of Physicians Ethics Manual mandates disclosure of errors if disclosure of this information is "material to the patient's well-being." Lois Snyder & Cathy Leffler, Ethics Manual, Fifth Edition, 142 Annals Internal Medicine 560, 563. Finally, the Joint Commissions on Accreditation of Health Care Organizations requires

that patients be informed of unanticipated results that differ from the expected outcome in a significant way when a medical error occurs at a hospital. Joint Comm'n on Accreditation of Health Care Orgs., Revisions to Joint Commission Standards in Support of Patient Safety and Medical/Health Care Error Reduction 12 (2001).

Disclosure of medical errors is not only ethically mandated, literature supports that it is consistent with the fiduciary nature of the physician-patient relationship, since in most instances, disclosure of errors will benefit a patient. C.J. Wusthoff, Medical Mistakes and Disclosure: The Role of the Medical Student, 286(9) JAMA 1080, 1081 (2001). Disclosure helps gain the cooperation of a patient who has been harmed by an error. Id. Further, understanding the cause of unexpected problems can relieve anxiety about recovery or complications. Id. Finally, some commentators have suggested that since patients need information about errors to make decisions about their medical care, disclosure of malpractice is part of a physician's duty to provide a patient with informed consent. Thomas H. Gallagher, Wendy Levinson, Disclosing Medical Errors to Patients: a Status Report in 2007, 177(3) Canadian Medical Association Journal 265 (2007).

In theory, physicians agree that they have an ethical obligation to disclose medical errors. One study suggests that between 70 and 90% of the physician population believes that doctors should disclose errors to patients. Kathleen M. Mazor et al., Communicating with Patients about Medical Errors, 164 Archives of Internal Medicine 1690, 1692 (2004). In another study, 97% of the faculty and resident population surveyed indicated that they would disclose medical errors that caused minor harm, and 93% indicated that they would disclose an error causing major harm. Lauris Kaldjian , et al. Disclosing Medical Errors to Patients: Attitudes and Practices of Physicians and Trainees, 22(7) J Gen Intern Med 988-96 (2007).

Regrettably, while physicians are ethically obligated to inform their patients of consequential medical malpractice and studies suggest they intellectually support this principle, theory has not translated into practice. A study revealed that only 24% of residents surveyed reported the medical errors they committed to their patients. Albert Wu, et al. Do House Officers Learn From Their Mistakes? 12 Quality & Safety Health Care 221, 224 (2003). Another study estimated that nationwide, physicians are only disclosing errors to patients about 1/3 of the time. Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors, 347 New. Eng. J. Med. 1933, 1935 (2002).

Doctors have always been ethically required to disclose medical errors, partially because it is a means to ensure good care. That has not happened though. Moreover, since To Err Is Human was published twelve years ago, saving 1.2 million lives was not enough incentive to cause error reporting systems to develop and preventable errors to be analyzed. Under the circumstances, it is absurd to suggest that (a) error reporting will increase and (b) a safer health care system will evolve once the impact of limiting malpractice victims' right of redress trickles down through the health care system.

Attempts to justify restricting the rights of medical malpractice victims as a means to decrease the cost of "defensive medicine" are misplaced because (a) the health care industry vastly exaggerates the problem of defensive medicine, (b) other factors have increased physicians' propensity to order more diagnostic studies and make additional medical referrals, and (c) studies have repeatedly shown that capping medical malpractice damages does not impact how doctors practice medicine.

Those who advocate tort reform often point to the problem of defensive medicine as a justification to limit the right of redress of victims of medical malpractice. The argument is that the "pervasiveness of malpractice litigation" causes health care providers to "order tests or procedures in excess of their actual need to protect themselves from the risk of lawsuits." Tara F. Bishop, MD, Alex D. Federman, MD, MPH & Salomeh Keyhani, MD, MPH, Physicians' Views on Defensive Medicine: A National Survey, 170 Arch Intern. Med. 1081 (2010). Accordingly, malpractice litigation is seen as creating a problem of over-deterrence, with lawsuits causing doctors to take more precautions than they otherwise should when they treat their patients.

Doctors certainly think the threat of malpractice causes them to be excessively cautious. Studies surveying doctors for the last 30 years reveal that anywhere between 21% to 98% admit engaging in defensive medicine. J. William Thomas et al., Low Costs of Defensive Medicine, Small Savings from Tort Reform, 29 Health Affairs 1578-1584 (2010). Nevertheless, it is hard to reconcile physicians' perception that they are acting in an overly cautious manner with reality. Although the last few years have seen an escalation in the discussion about the costs of defensive medicine, over-cautious behavior is not evident in outcomes because medical error rates have held steady. Christopher P. Landrigan, M.D. et aI., Temporal Trends in Rates of Patient Harm Resulting from Medical Care, 363 New Eng. J.Med. 2124 (2010).

Bias is one culprit here, as some commentators have pointed out: "Because many physicians are attuned to defensive medicine as a problem, and their professional organizations agitate prominently against it," studies that attempt to quantify the scope of the problem of defensive medicine by surveying physicians are prone to a "socially-desirable response bias." David M. Studdert, LLB, SeD, MPH, et al., Defensive Medicine and Tort Reform: A Wide View, 25 J. Gen. Intern. Med. 380 (2010).

In addition to the problem of bias, surveying doctors to attempt to determine whether the threat of a medical malpractice lawsuit causes over-utilization has other inherent defects. First, there are many other causes for profligate testing in medicine, including: 1) the public culture of entitlement; 2) the expectation of immediate and perfect results; 3) the extraordinary increase in diagnostic and treatment options today; and 4) growing specialization and fragmentation of care. Marcel Frenkel, M.D., M.B.A., Consensual Medicine and the Therapeutic Partnership: Reducing the Costs of Defensive Medicine and Litigation, 25 J. Med. Prac. Mgmt. 78 (2009). Additionally, managed care contributes to over-ordering because it requires faster analysis and decisive conclusions. Id.

Studies that have attempted to quantify the costs of defensive medicine by looking at the impact that tort reform has had on health care savings have obtained inconsistent results. For example, while some studies have found lower health care costs in states with tort reform, others noted a weak relationship between tort reform and health care savings. Still other studies found no relationship at all. J. William Thomas et al., Low Costs of Defensive Medicine, Small Savings from Tort Reform, 29 Health Affairs 1578, 1579 (2010). These varied results have been attributed to the fact that researchers invariably focus on limited sets of clinical conditions or specialties. Id. at 1579.

In 2009, a broader and more comprehensive study was undertaken to ascertain the impact of tort reform measures on health care costs by examining Medicare spending in states that adopted tort reform. Frank A. Sloan & John H. Shadle, Is There Empirical Evidence for 'Defensive Medicine'? A Reassessment. 28 J. Health. Econ. 481 (2009). The study concluded that its analysis, and those of previous studies, suggested that contrary to statements in the media, caps on damages and the abolition of punitive damages did not have a significant

impact on the reduction of payments for the studied Medicare services. The researchers' overall conclusion was that "tort reforms do not significantly affect medical decisions, nor do they have a systematic effect on patient outcomes." Notably, these results meshed with the Congressional Budget Office's estimate that if tort reform were enacted in the form of a $250,000 cap on noneconomic damages, a $500,000 cap on punitive damages and a decrease in statute of limitations, the savings from a combination of: 1) decreased use of services from less defensive medicine; and 2) lower malpractice insurance premiums would be merely .5% of the annual national expenditure of health care. Cong. Budget Office, Letter to Honorable Orrin G. Hatch, U.S. Senate, Oct. 9, 2009, available at www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Refrm.pdf.

Finally, at face value, the defensive medicine argument is premised on an outdated and paternalistic view of the physician/patient relationship that is contrary to law. In most circumstances, the law compels physicians to empower their patients to make consequential medical decisions by requiring a doctor to provide a patient with informed consent. Simply put, it is a mistake to assume that reduced exposure to liability will allow doctors to be less cautious, because doctors are no longer the only decision makers in this process.

By capping recovery, H.R. 5 will inadequately and arbitrarily compensate victims of severe incidents of medical malpractice and simultaneously make smaller medical malpractice cases economically impossible to pursue. This later problem will have a disparate impact on the poor and elderly.

It goes without saying that an arbitrary cap on non-economic loss damages will negatively impact victims of medical negligence injured the worst. In addition to this, damages will make cases for many victims injured less severely by medical malpractice financially unviable. Medical malpractice case usually require a plaintiff's attorney to "front" expenses. Even the most simple cases this amounts to at least $25-$30,000. The costs are significantly more if the case goes to trial. More importantly, these cases also almost always require a malpractice victim's attorney to invest hundreds of thousands of dollars in attorney time to prosecute, because they deal with complex issues of science, require extensive discovery and significant preparation during every stage of the litigation process and they are always vigorously defended. Assuming a contingency fee of 33%, a case usually has to have a potential financial recovery of over several hundred thousand dollars for an attorney to consider it financially viable to pursue. Therefore, if damages in these cases are capped at $250,000, unless a patient suffers a significant future loss of income as a result of a medical mistake, the overwhelming majority of medical malpractice cases will no longer be financially viable for attorneys to prosecute. Make no mistake about it, capping malpractice damages in the face of a permanent life-altering injury at $250,000 will hurt nearly every medical malpractice victim. Nevertheless, since a significant future wage loss will become the new polestar of whether a malpractice case is financially viable, H.R. 5 will disparately impact the elderly, who do not have a lengthily work life expectancy, and the poor, who will not show a dramatic future wage loss.

Conclusion

Juries sit on cases every day in the United States and determine whether accountants, attorneys, architects and engineers commit professional malpractice. Indeed, we rely on our citizens to determine whether some criminals should be sentenced to death. H.R. 5 assumes that juries are incapable of deciding the appropriate measure of compensation for people who have been injured by a health care provider's negligence. Notably, H.R. 5 does not posit

that people are ill-equipped to deal with complex medical issues, and it does not suggest that a jury cannot determine whether a medical provider made a mistake, it simply assumes people aren't smart enough to calculate what amount of damages should be awarded to patients injured in these circumstances. The fact is that juries make this identical determination in virtually every significant civil case that is decided by the courts, and no cogent explanation has ever been offered about why juries are uniquely incapable of making these kinds of calculations in medical malpractice trials.

Like every other business industry, the health care industry is influenced by a profit motive. Promoting safety is time consuming and expensive. Historically, lawsuits have actually helped advance safety measures in industries reluctant to take such initiatives on their own. In the face of a medical malpractice problem that by its own admission has reached epidemic proportions, the health care industry failed to take significant measures for the last twelve years to stop hundreds of thousands of deaths. A reasonable analysis leads to the conclusion that H.R. 5 will only exacerbate these problems.