

NEW YORK STATE BAR ASSOCIATION  
HEALTH LAW SECTION

---

PANEL DISCUSSION ON MEDICAL MALPRACTICE

---

Nixon Peabody LLP  
677 Broadway, Tenth Floor  
Albany, NY 12207

August 13, 2009  
10:10 a.m.

MODERATOR:

Martin Bienstock, Esq.  
Member  
Wilson, Elser, Moskowitz, Edelman & Dicker, LLP

PARTICIPANTS (Via Videoconference):

Edward Amsler, Esq.  
Vice President  
Medical Liability Mutual Insurance Co.

Bruce G. Clark, Esq.  
Principal  
Bruce G. Clark & Associates, P.C.  
Mr. Clark is a trial lawyer whose practice is limited to representing plaintiffs in medical malpractice actions, and is an Adjunct Professor of Law at Hofstra University School of Law

Susan C. Waltman, Esq.  
Executive Vice President and Chief Counsel  
Greater New York Hospital Association

- I. Introduction.
- II. Health Courts
- III. Expert Identity and Depositions
- IV. Physician's Authority to Consent to Settlement
- V. No-Fault Insurance for Medically Impaired Infants

- VI. Caps on Damages for Pain and Suffering
- VII. Disclosure of Physician Conflicts
- VIII. Concluding Remarks.

## **I. Introduction.**

BIENSTOCK: We've convened today a panel of experts to discuss reforming the New York State medical malpractice system. Our panel is meeting at a fascinating time. Congress is home on recess, and members are holding regular town hall meetings to discuss the prospect of wide-ranging reforms to the healthcare system. At the same time, more locally, New York State medical malpractice insurance companies are facing significant financial strains, due in part to increases in the size of medical malpractice awards.

While physician rates have been frozen, hospitals are facing significant rate increases or, for the self-insured, significant payouts. And despite the rate freeze, physicians in some areas and some specialties pay extremely high medical malpractice insurance premiums.

For that reason, one issue that some would like to see on the reform agenda at the state or the national level is the issue of medical malpractice. Medical malpractice reform raises a number of important policy issues, and I'd like to touch on them a little first before we head into our panel discussion.

On the one hand, medical malpractice liability payments impose a significant direct cost on the healthcare system, as money that might otherwise be spent on providing treatment is instead paid out to medical malpractice claimants or toward supporting the overhead of the system. Those direct costs are swamped, some say, by the indirect costs of the medical malpractice system, as physicians engage in defensive medicine and order costly and unnecessary tests and treatments. All of these costs might otherwise be directed to improving coverage.

Now, on the other hand, hundreds of years of common law support the underlying principles of the current system. Physicians and hospitals owe their patients a duty of care. And when they breach that duty and injure their patients, they should be made responsible to make

them whole. Not only do the injured patients themselves benefit from the medical malpractice system, but the system itself, the healthcare delivery system itself, is better off.

What some deride as defensive medicine others praise as ensuring that the duty of care is provided. These people argue that physicians should take the steps necessary to ensure that they do not injure their patients, and the threat of a malpractice suit is necessary to make sure that they comply with this duty.

Not only that, the medical malpractice system can provide an impetus to comprehensive reform of medical practices. At the least, the lawsuits themselves help identify the flaws in the individual systems. Sometimes lawsuits can help drive reform across an entire industry. The poster child for this type of reform is in the practice of anesthesia, which in response to a medical malpractice crisis reengineered entirely the way that it does business and drastically reduced the incidence of bad outcomes.

Of course, no one is proposing here to abolish the medical malpractice system. The reforms under discussion today will address some aspects of the system, and each has its own advantages and disadvantages. Of necessity, though, one's views on these reforms will be colored to some extent by the prism through which you view the entire system.

## **II. Health Courts (and Clinical Guidelines)**

WALTMAN: There have been many discussions about the need to improve the dispute-resolution process for medical malpractice cases. I recognize that when we start to talk about that issue, it often leads to a very explosive conversation. In my view, that very result proves the need to improve the process: when key stakeholders are unable to even talk about the need for change or how well the system works, I think it demonstrates the amount of acrimony that the system breeds.

I'm a big supporter, actually I'm a very big supporter of the judicial system and how it works in the United States. But when you look, factually, at aspects of the way the medical malpractice system works—or doesn't work-- today, I believe it militates in favor of an improved process for resolving these claims.

First, there are many barriers to entry into the court system. A lot of people, meaning a lot of potential plaintiffs, are unable to enter the court system today because it is so costly, and because it is often difficult to find attorneys to take cases, not just because of the complexity or acrimony of the process itself but again because of the costs associated with navigating it.

Second, the cases themselves take a very long time to wend their way through the judicial system. There are two sides to that story, I recognize. But one way or the other, a tremendous amount of costs are consumed by the medical malpractice dispute-resolution process. Indeed, studies indicate that an amount equal to 54 percent of the compensation paid to plaintiffs goes toward the administrative costs of the system.

Third, the system is very costly for providers. I will run through those costs quickly.

We project that more than \$1.6B or more than 3 percent of New York State hospitals' operating costs is spent on medical malpractice coverage. If you look at those costs in relation to hospitals' total non-labor costs, it translates to more than 8 percent of hospitals' non-labor costs going toward medical malpractice dispute resolution.

That's a lot of money. I know that sometimes people will say that medical malpractice costs aren't really that high. But for our member hospitals an extraordinary amount of money goes into covering the costs of the medical malpractice dispute resolution process. There is also, as you note, Marty, the larger cost of defensive medicine, with experts projecting its cost being anywhere from \$25 billion a year to \$190 billion, which is quite a large range, I recognize. Some people will say that not all "defensive medicine" stems from providers worrying about lawsuits, and I am willing to accept that. But there are still a lot of resources being devoted to the medical malpractice system and the related practice of defensive medicine. With that background in mind, I will move to my initial set of recommendations. I strongly urge, particularly in the midst of a discussion about health reform, that we look at meaningful ways to improve the way we resolve medical malpractice disputes. I therefore put forward the notion of health courts. I recognize that some people object to the idea of health courts in the purest sense, meaning they do not support establishing administrative systems for resolving disputes. But I do think that we need a system, whether it's judicial or administrative in nature, that recognizes the special nature of these kinds of claims, their cost to society at large, and the problems that arise from them. Therefore, I strongly recommend the establishment of health courts that would use

specially trained judges; neutral experts, as needed; clinical practice guidelines, both to facilitate the dispute resolution process as well as to protect those who follow them; and, finally, general guidelines for compensation, particularly noneconomic damages -- not necessarily caps, but guidelines. Taken together, these features would help improve the dispute resolution tremendously.

As part of the federal reform discussions, we have actually suggested creating special federal courts, or actually federal health courts, similar to bankruptcy or patent courts.

Regardless of the approach, I do hope, for the benefit of plaintiffs, providers, and society at large, that we can identify a better way to handle these disputes.

BIENSTOCK: So, Susan, are the highlights of your proposal specially trained judges, neutral experts, guidelines for compensation -- and was there a fourth?

WALTMAN: Yes, using with the fourth feature being clinical practice guidelines that can frame and inform the court's deliberations.

I think clinical practice guidelines can do two things. They can help shape and drive the delivery of better health care on the part of providers outside the courtroom, and they can also be used by providers to demonstrate that they have not been negligent in the delivery of care when they must respond to a claim in the courtroom.

BIENSTOCK: Would you propose that juries be permitted in these courts, or are you doing away with the juries?

WALTMAN: I have not taken a specific position on that point. I think the purest, most efficacious way would be to have just a judge. But I recognize that's a flash point.

I have purposely laid out considerations that I think will improve the process from the standpoint of all of the parties involved and have tried to minimize the flash points as much as possible.

CLARK: Let me respond. Let's look at what has happened in medical malpractice law in recent years, the statute of limitations was reduced from 3 years to 2 1/2 for adults and from 21 to 10 years for children, the fee for plaintiffs' attorneys has been reduced from one-third to a

sliding scale that goes down to 10%, then the medical malpractice panel was introduced. And that was a panel in which there was a doctor, a lawyer, and a judge. And if they were unanimous in their findings of either liability or non-liability, that could be mentioned to the jury.

We found that the findings of juries tended to be almost diametrically opposite from the findings of the panel.

The panels also ended up in delaying malpractice cases, the resolution, for years, sometimes seven or eight years, because they were waiting for a panel. In Suffolk County, one law firm represented most of the doctors, and it was impossible to get a panel that did not have any kind of connection with the Wortman law firm.

So that was another reason why the panels did not work and where special malpractice courts, as it were, in microcosm was not a functional system.

As a practical matter, right now we do have malpractice courts. If you go to New York County -- and in almost every county -- there's a select group of judges who are the brightest, the most experienced judges, who have experience and who are qualified, who are assigned the malpractice cases. Malpractice cases don't go to the new judges, the uninitiated, or the judges who don't know what the law is. So we do have malpractice cases being tried in malpractice courts by judges who are competent.

Most plaintiff's attorneys will not bring cases in the federal court because, while it might be a few months less processing time, to bring a case in the federal court results in probably twice the expense it takes to bring in the state court. Moreover, each federal judge has her own case load, including criminal cases. It is not uncommon for a federal judge to give a "rigid" schedule for the prosecution of the case with a definite trial date, only to have the judge start a 2 month criminal trial the week before the malpractice case is to be commenced. It is also very rare to find a federal judge who had any experience with medical malpractice cases before ascending to the bench or who has presided over medical malpractice cases as a judge.

Clinical practice guidelines, that's what medical malpractice is. If a doctor departs from the accepted standards of medical practice in treating a patient, that is malpractice. Negligence in medical malpractice is a departure from the accepted standard or departure from the practice

guidelines. Regularly in the trial of these cases we'll look at the standards of the American College of Obstetricians or the published standards of other specialties as guidance.

Paradoxically, an expert witness, on direct examination, cannot support her testimony by referring to a publication, be it a standard published by the specialty board or a learned treatise or article in a medical publication. The expert can, however, on cross examination be confronted with those publications in an attempt to impeach the expert's testimony on direct examination. The federal courts allow publications to be admitted into evidence. In my opinion, the state practice is more likely to result in a better verdict. As far as I am concerned, the system ain't broke and it doesn't need fixing.

AMSLER: Can I chime in here? Especially as to that last point, I think we need to take a look back and ask: "is the system broken?" Is the system working? There's no question it is broken. It is working to serve society? Is it working to serve those who are truly injured as a result of malpractice? I submit to you that it doesn't work.

We have a system here which, if you wanted to have a yardstick to judge it by, you'd measure whether it is efficient, equitable, and predictable. Well, it's none of those in terms of goals.

It's not efficient. It spends more money in its process than it does in payments to truly injured patients. As Susan pointed out, over 50 percent of the money goes to the costs of litigation. That's not just plaintiff's attorneys, I don't mean it that way; I mean it's plaintiff's attorneys, it's defense attorneys, it's expert reviews, it's costs associated with the litigation.

And yet in our insurance company, which is a mutual insurance company owned by the physicians and hospitals, we closed, last year, close to 70 percent of our cases without payment. So, if you're closing all of these cases without payment, a major driving force behind it is the cost of defending these cases and the cost of litigation that's involved in it.

Is it predictable? It's wholly unpredictable. Same person with the same injury: Different juries, different location, different geography, different result. Depending upon expert testimony, sympathy for the plaintiff, experience of the ligator, venue -- all of those elements go into making it an unpredictable system.

So it has always been my opinion that I don't think the system is serving society well at this point. And I think it's antiquated in terms of the needs of society and both patients and physicians and hospitals in that regard.

To analogize the old medical malpractice panel system to a medical court I don't think serves any of us well, because in the old panel system, remember, had a doctor, a judge, and an attorney. And one of the major problems with that was there was never any unanimity. There would always be a split panel, delays involved -- and I agree with Mr. Clark completely, there were delays involved in it. And it wasn't efficient, because even after long delays in getting those panels done, 90 percent of the time they were split panels and they became nonentities, as they weren't admitted into evidence.

I think that we need to take a fresh look at this with those people who truly have an interest in the injured patients. Are they being compensated effectively?

There are cases that we try to a conclusion which result in defendants' verdicts which others may disagree that it should have been a defendant's verdict and the exact opposite occurs, because there is no predictability under it. I know parameters have been tried in Maine, to a degree, and I think that there is a presumption of non-negligence in certain specialties if they adhere to certain practice parameters.

It's the same story with many of these proposals: the devil exists in the details. You don't know how effective practice parameters will be. I know a lot of physicians are concerned that it will result in "cookbook medicine" if a patient comes in with a certain clinical presentation they'd be required to render care in a cookbook fashion in order to obtain a presumption of no negligence.

So I know there is some objection to it on that basis, and the parameters are the types of things that you have to analyze. Although I must say that practice parameters would give predictability to the system, which we currently don't have.

And the thought that currently the system is really dealing with parameters I don't think is accurate, because the parameters really are dependent upon the expert who testifies, both for the plaintiff and for the defendant. And if we did not have a dispute between those experts, we

wouldn't be having a trial. Hence the parameters certainly aren't in agreement between plaintiffs and defendants, and that's what's generating litigation.

BIENSTOCK: Isn't it the case, though, that any kind of dispute-resolution mechanism is going to be messy? And the one that we've arrived at is the one that we as a society think is best. So in the example of, for instance, neutral experts, we don't use neutral experts in litigation. That's not where we've gone. There's an assumption that the adversarial process will produce a better source of truth than would a different system. They may use a different system in France or on the European continent. We use the adversary system.

And so why would it be that you think these types of disputes are especially amenable to specialized judges, neutral experts, compensation guidelines, which are usually the province of the jury in our system?

WALTMAN: I believe there is a strong case to be made that health care is a special area. Not only, as some argue, because it's beyond the knowledge of certain judges or juries, but because health care, in general, is so costly and because medical malpractice costs, together with the cost of defensive medicine, represent such a significant portion of health care costs. Quite simply, as the nation undertakes health reform, it should also look at fair and effective ways to reduce medical malpractice costs as well. I assume Mr. Clark may talk about other ways to reduce those costs, such as reducing adverse outcomes, and I subscribe to those ways to reduce costs as well. That is exactly what GNYHA is doing with its member hospitals, namely, trying to assist them in reducing adverse events, reducing costs, and improving the efficiency and effectiveness of the care that they deliver.

I would suggest, however, that because health care consumes such a large portion of our nation's resources and because medical malpractice costs in particular represent and/or drive such a large portion of our health care costs, medical malpractice claims deserves special treatment within our judicial system.

I emphasize that I do not want to undermine the rights of the parties to medical malpractice disputes. Our country was founded on a commitment to certain rights, and I don't mean to throw those rights to the winds. But I believe it is important to look at ways to improve

the dispute resolution process so that more people can enter the system and cases can move more quickly and be disposed of more fairly

In the end, I would hope that whether you represent plaintiffs or defendants, you would agree that there are improvements that can be made in the processing of claims.

On clinical practice guidelines in particular, yes, there are a lot of guidelines that are available.. I am suggesting, however, that someone such as the Secretary of Health and Human Services bring together professional societies, provider and consumer groups, and other stakeholders, and that they would, by consensus, identify clinical practice guidelines particularly in certain high-risk areas. Without that consensus approach, what occurs is too often a battle of the experts as to what guidelines should control. I was recently looking through some of the health reform proposals, and there are many, many provisions that discuss best practices, quality measurements, comparative effectiveness, and so on and that's exactly why we have battles of the experts in the courtroom today. Perhaps some might say that having the right to put forward the guidelines that serve your purpose is what the United States is founded upon, but it's a shame that so much time, energy, and resources go into the litigation of medical malpractice cases.

CLARK: Could I tell you a little bit about what happens in my office? I probably get inquiries of about 200 cases a year. Before I spend any money, I will meet with the client, I will speak with the client or an attorney in my office will speak with the client, and we'll winnow those 200 cases down to maybe 50 that sound like they have merit.

Then of those 50 I will gather records and we'll investigate them ourselves, we'll evaluate them. And then from the 50 we'll take about 20 that we will proceed with, and there we will hire the best-qualified experts we can have to analyze and tell us if we have a case. And ultimately we come down to, out of the 200 cases, maybe we've taken 10 or 12 cases a year, and we work them very hard.

But I have spent, in the course of preparing these cases, tens upon thousands of dollars, which you're not paying and which the healthcare system is not paying. So I am winnowing down the cases and restricting the cases that I commence to the ones I feel are merited.

Basically, the doctors, the courts and the medical system are not troubled by cases that are insignificant. The system has evolved to provide a day in court for those with serious injuries.

And I can't afford to take bad cases. I can't afford to take phony cases. Because I'm going to spend 20, 30, 50, sometimes \$80,000 to prosecute a case. And if the client is a phony or the injury is a phony, Mr. Amsler's people are going to kill me, and I'm going to be out 20, 30, \$50,000. Sometimes he'll kill me on the good cases.

AMSLER: We can but hope.

I just want to make a point that I think when we look at reforming the system -- and I think Bruce very cogently makes the point -- there are a lot of cases out there that don't see compensation yet really involve malpractice, and the reason they don't is because they don't have the financial impact that would drive an attorney to take the case. So I think when you reform the system, you are going to open up the funnel of the system to smaller cases and increase costs on that basis.

Now, I'm not saying that reform of this system is going to be less costly, ultimately, because, as you point out, it's very difficult for a competent plaintiff's counsel to accept a case that only has minimal financial value because of the costs involved in bringing the litigation. That is the hurdle over which they have to go in order to commence the case. So aside from the negligence itself, it's also the potential financial return.

So one of the problems with our current system is that it precludes these cases that have absolute liability in them but don't have significant enough damages for counsel to take them.

WALTMAN: Bruce, I respect how you handle your cases. And that's always the problem of having these kinds of debates; we should not be painting everybody on the other side with the same brush.

But do you have a comment about the fact that at Ed's insurance company, they close 70 percent of the claims with no payment? So what is happening there??

CLARK: What happens is there are attorneys who handle automobile cases, and in the course of handling an automobile case maybe the patient, after the initial impact, has an adverse

result. And they will say, “Oh, this sounds like a great medical malpractice case.” They’ll get involved, they’ll spend the \$10,000 or \$20,000 to prepare the case, and then they’ll lose it. They’ll be one of those 70 percent of the cases.

And then the next time they get a case in, they’re still smarting from the expense of the first one, they’ll send it out to somebody who is a specialist.

BIENSTOCK: Let me offer a different explanation, which is that the system is designed, you know, so that you can file a complaint without knowing much about the facts of the case and you often don’t really learn much about the facts of the case until you’ve had a chance to sit down with experts and maybe to depose the doctors and the nurses and to find out what happened.

And, you know, certainly my professor friends say there’s an argument in favor of that process, because without it you can’t necessarily identify what really happened. Certainly there should be an interview process up-front to weed out the cases where you’re going to waste your money. But even then I suspect you’re still going to get plaintiffs who come in through the door, sound like they’ve got a good case, something bad happened that shouldn’t have happened, and it isn’t until you’ve done some discovery that you can figure out that maybe no, there isn’t any case here.

CLARK: That’s right. And you will have that same discovery process if you open the whole process up to every claim where somebody says “I had my appendix taken out and now I have a scar on my abdomen.” That type case, maybe there was negligence that resulted in a little bit larger scar than you would expect. But in all those cases, in all those compensation-type situations, if you’re going to let everybody recover, that’s not going to save any money.

WALTMAN: –I believe that both Ed and I acknowledge that making improvements to the system may mean more claims may come into the system. But if you could start afresh and focus on what could make the system work better, you would hope that, in the process, more people could appropriately enter the system and yet have the system cost less overall. . Currently, however, there is a considerable access problem, and yet the system costs so much.

I don't want to open the floodgates necessarily either, but I think that the current system is unnecessarily expensive, perhaps not the way you approach it, Bruce, but overall, it's an exceptionally expensive system. But how would you go about improving the dispute-resolution process in order to allow more of the money to either go to the plaintiffs or stay in the health care system?

AMSLER: Marty asked the question as to the efficiency of the advocacy process: equally competent counsel on both sides in front of a jury, and it will render truth. I was trained in that and still practice it, and believe in it.

But society progresses. And just because we have done the same thing over all these years doesn't make it necessarily right. And if we still had that process, we'd be having employees suing employers and we wouldn't have a Workers' Compensation system.

The provision of healthcare in this country has become such a monumental issue at this time, as well as the costs associated with it. As lawyers, I think we need to take a hard look at whether this is the best way to be addressing this problem. Are there more efficient methods, we've seen arbitration, for example, come about in all forms of litigation, commercial litigation, because people recognize the efficacy of binding arbitration in those actions. But we refuse to recognize it in this area.

So I think we need to put different lenses on and take a broader look at it, as opposed to relying on what we've always done.

### **III. Expert Identity and Deposition**

AMSLER: Sure. Let's talk about procedure, if we can, for a moment. I've always been concerned that here in New York State, we don't have the capacity to both identify and depose experts on both sides. We have what is classically known as "trial by ambush".

And I've been in the courtrooms where you sit there and you've got your associates sitting next to you and you've got them running outside trying to dig up transcripts on the name who you've just found out or, in current practice, trying to discern who the expert would be based upon the identification that you've received pursuant to the CPLR, which excludes the name.

And to me, it's antiquated and it's almost irresponsible at this point for our system to do that. Every other state has at least identification of experts. And under federal rules, you have depositions. And why is that good? I think it's good for several reasons. One, it's good for both sides to understand what the theory is upon which the litigation is founded.

With a lot of counsel, a lot of plaintiff's counsel nowadays -- and we're doing a lot more mediation than we ever did in the past, and we've found that experienced plaintiff's counsel nowadays are not disinclined to give us the name of the expert and what the theory is, because they feel they've got a solid case and this is their theory.

And what that tells us is that, okay, here's the theory. Do we agree? And, we have a physician-owned company, and the physicians reviews it. They say: "Well, here's the plaintiff's theory. Is this right? And if this is right, maybe we ought to get out the checkbook, as opposed to spending three weeks in trial."

If you had discovery and you had depositions, you have an opportunity to understand the opinion, the basis for the opinion, the effectiveness of the opinion, and the causal relationship between any departure and any damages that are there. What it does is it limits the scope of the case so that you really know what the issues are.

Every other state has it. The old argument 10 years ago, 20 years ago used to be that there's this: "conspiracy of silence" out there, and if we tell you who the name is, nobody will come in and testify. As Mr. Clark points out, he goes out and gets the most experienced experts to review these files. I don't know that any plaintiff's counsel has difficulty getting experts to review these files, nor is there a conspiracy of silence in the current milieu in which we practice.

So I think it's time to, bring this into the 21st century and have discovery of identity. And it's going to increase the defendant's costs, obviously. I mean, we're going to spend money to depose experts, and that's going to cost a great deal of money to the insurance carriers. But the net effect of that is going to be faster resolution, because you're going to know the theory, you're going to settle the case earlier. And if you think the plaintiff has a solid theory, you can define the causation on it.

So you're going to have to balance that increased cost against earlier resolution of these cases. The later, the earlier resolution, I think is of benefit to both the system and to society as a whole. So I think it's time we moved in that direction.

CLARK: As a practical matter, Ed refers to Civil Practice Law and Rules 3101(d), which requires you to disclose the qualifications and the summary of your expert's position.

We have computer programs, both the defense and the plaintiff's bar, by which we can put in the doctor's medical school, his internship, his residency, and the computer will spit out five names that have those three correlates, and then from those we can usually figure out which one is going to be the expert for the other side. And the defendants do that also.

And I have had many trials where the defendant has a porter come in carrying boxes of transcripts of testimony of my expert, and they know what he's said and where he's testified before.

And we are also precluded from asking the expert questions if we don't disclose what his position is. And we have to disclose that beforehand. So they are getting practically everything they need. And if they don't get enough in my 3101(d) statement, they go to the court and they say, "We either want to preclude him from offering anything else, or we want more information."

And there are cases now where you have to provide every publication that the person has ever given. So as a practical matter, they are getting all those things. And I agree with Ed that there should be earlier resolution. And that's one of my positions, that with earlier resolution everybody will save money.

BIENSTOCK: Bruce, what about depositions? What about expert depositions?

CLARK: The depositions are expensive. They delay the case. They require extra preparation. And we all know what they're going to testify to anyway.

I don't think it's a big secret when, you know, if a child is dropped on his head in the delivery room or the nurse ignores the patient when the patient says the baby is beginning to have seizures or something like that. So I think it rarely would benefit.

AMSLER: You know, I think it's almost silly, it's just like playing cards and saying "I have a card that's somewhere between a 4 and a 6, and you've got to guess what it is."

Now, if everybody knows what it is, what are we really doing here as lawyers, as rational beings? Is this really what we want to be doing? If everybody is using computer programs to guess who the other expert is, why don't we just say "This is my expert"?

CLARK: That's what I do.

AMSLER: So why don't we have a law that says you've got to do that?

And the value of taking depositions is not just a theory on liability, but it's also on damages. In many of these cases -- in fact, the vast majority of these cases -- patients don't go to physicians or hospitals because they're healthy. Most of them go there because they have a problem and there is an underlying problem or a preexisting condition that we're dealing with. And differentiating what the difference is between the alleged act of negligence in terms of damage caused versus what the underlying condition caused is oftentimes a determining element in the value of the case, so you determine whether the case is worth X number of dollars or Y number of dollars.

Now, if you have an expert who testifies and renders an opinion as to what the causal relationship between the alleged negligence is and the damages, then the defendant is put in a posture of evaluating if it's related to all of these damages so it has X value or it has Y value because it is only related to more limited damages.

Otherwise, it's playing a game of "I'll tell you at the trial," and the expert will come in and testify then, and it's subjected to cross-examination where you can whittle down the causal relationships. Well, by that time, the lines in the sand have been drawn and it's very hard to settle cases. You can settle cases years in advance if you can define what the damage elements are.

WALTMAN: Marty, you know that I don't do medical malpractice litigation, but rather I work in the area from a policy and advocacy position. I have to say that I found it fascinating to learn that, in the State of New York, you don't have the right to know the name of the opposing

party's experts and you don't have the right to take their depositions. It is a very "interesting" phenomenon in our State's procedure.

Our hospital members will say to us -- and I note that I rely heavily on individuals in our hospitals who are strong claims managers, all of whom also care deeply about the quality of the care that's given to their patients-- "if I could take the expert's deposition and learn more about the theory of the case, I would be in a better position to settle more quickly."

They thus describe the ability to depose experts as a way to understand the claims better and thus settle them more quickly.

CLARK: I do disclose what the theory of my case is. I don't dare not disclose it. Because if I have not disclosed it in the 3101 and the bill of particulars, when we get to trial the defendant's attorney stands up and he says, "This is a complete surprise. Mr. Clark should be precluded from proving this theory of liability."

And I've seen it happen. If you have not given adequate notice of what your theory of liability is, the defendant wins his motion to preclude you.

And as I said, as a practical matter, everybody knows who the expert is going to be. So we don't need new law for that. The law has been evolving. Initially, in the Jasopersaud case, you were protected from disclosing anything that would lead to the identity of the expert. Now there's an Alleyne case which says you have to disclose every writing that your expert has ever done. So if you disclose 10 articles and they all have one person in common, there's the expert. And if the computer program doesn't work, then you do it the other way.

So you really don't need that at this point. It would just delay things more. It would make things more cumbersome.

WALTMAN: I have sat through this discussion before, and I appreciate the fact that you can glean what the arguments and theories are and that the plaintiff can be penalized if he or she doesn't put those theories forward. It is just an "interesting" aspect of the state's judicial system that you cannot take the deposition of the other party's expert in order to learn more about the theories behind a claim.

BIENSTOCK: Bruce, Ed says that the original purpose of this was to protect the physician, the testifying expert physician from retaliation on the part of his peers, and that that's long gone because the identity is there. Is that your sense as well, that that idea of protecting the doctor from being viewed as a rat is no longer operative?

CLARK: I don't think it's no longer operative. And the way I overcome that is I try to get experts who are invulnerable to pressure. I don't ask for a doctor who's just completed his residency and is in his first position after he's become a specialist, because nobody is going to go to him. Or I don't go to the doctor who relies on referrals from people like the doctor I'm suing.

I have experienced it bitterly where my expert has been reached or intimidated from testifying. It's happened enough that I have developed defensive postures against it.

So there is a reason to do that, but we get around it by getting people who are very well qualified or who are retired and who cannot have their position taken away from them, who will not have the chief of their department come up to them and say, "Did I hear that you're testifying against Dr. So-and-So? You know, that's not going to be very good for your career."

I've seen that happen many times, and that's the underside of trial law, that people get intimidated and people get threatened. Sometimes it works.

WALTMAN: I will say again, for all the discussion that takes place about wanting to maintain the judicial system and respecting the tenets of the judicial system, it remains amazing to me that you can't take the deposition of the other party's experts.

#### **IV. Reducing Cost Associated with Physician's Authority to Consent to Settlement**

CLARK: Well, I think leading into from what we've said, one of the reasons that medical malpractice is as expensive as it is -- and I will not grant that it's as expensive as Susan says. I think that we don't have complete disclosure of what the real finances are of the field. And I would like to know how much profit the MLM is making, or --

AMSLER: I'd love to answer that one (laughing). The answer is zero. Absolutely zero.

In fact, recently, with the rate freeze and everything else, our surplus, which is the money that we need beyond the reserves that we have to pay claims -- a surplus is a rainy-day fund by

which the industry judges the financial security of insurance companies -- has been diminished from \$1.5 billion down to \$275 million, as the net result of reserve increases, assessments put on by the state, and the failure of the state to permit adequate rate increases.

So the fact of the matter is Medical Liability Mutual is a mutual insurance company owned by its insureds. If they ever made a profit, it goes back to them via dividends. They are not making any profit, and they're not designed to make a profit. Every rate request that's put into the Insurance Department is put in on the basis of the ultimate claim's costs minus the investment income that's intended to be derived during the course that the money is held.

Medical Liability Mutual is not a profit-making company. There are no large profit-making companies, no commercial carriers which write that business in this state. And there's a reason for that. It's because it's not a profit-making business. You don't have AIG, you don't have Aetna. You don't have profit-making companies in this state because historically profit can't be made in it.

So, I'm glad to respond to that. I think that any argument that this is a profitable business is fallacious on its face and it shouldn't be discussed, in terms of dealing with this problem and this issue.

WALTMAN: I find that often when we have the debate about the costs of the medical malpractice system, people will say, let's look hard at what the insurance companies are doing, maybe they're making too much money.

However, most hospitals in New York State are not covered by commercial insurance because it isn't available to them at any reasonable price or perhaps not available at all. They therefore have established self-insured trusts or captive insurance companies. Under those arrangements, and similar to what Ed described with respect to his company, if there is any extra money, it would go back to the hospitals. So, the concern that insurance companies are somehow making too much money or requiring excess reserves shouldn't arise in New York State.

CLARK: Well, we've been talking about costs of litigation, and litigation is expensive for both sides. The way the malpractice law is structured in New York State at this time is if a

doctor settles or loses any combination of two cases, this goes onto the data bank, and patients can access what the doctor's record has been.

So the doctor -- and in many of the cases, in most of the cases, my understanding is the doctor has the right to refuse to consent to a settlement. So what happens is the doctor says, "If I settle this case, my name is going to go onto a data bank, and it's going to hit me in the wallet because patients are not going to come to me when they see I've had three lawsuits against me that I've settled."

So I think what would expedite cases infinitely would be to eliminate that provision of the law that says doctors have to report and doctors' names go into a data bank if they settle cases. Let it be if they lose cases.

I have cases -- right now I've been dealing with a client who has a potential multimillion-dollar case, and his house is being foreclosed on right now. I can't call you up and say, "Ed, you know, you're going to owe a lot of money on this case." My experience is you just don't pay until you've had all the disclosure, and then the doctor is going to say "I'm not going to do that, I want the hospital to pay."

So this case that you could probably settle for half the value at this point, you will not be able to because the doctor will not consent at this point. So I will then take the case to trial, and instead of settling it for a million dollars now, I'll get a \$3 million verdict. And just because of the exigencies of the doctors having to disclose and be reported on cases that he or she has lost.

AMSLER: I think Bruce makes a valid point to an extent. I think one of the unintended consequences of these levels of transparency of malpractice litigation -- and they include, at the national level, the National Practitioner Data Bank. And then there's the state level where there are also reporting functions. And it's also at HMOs and for hospital privileges. All of these organizations have to be reported to if you've had a malpractice case, a malpractice settlement, or a malpractice judgment.

So it's not just the National Practitioner Data Bank, it's this transparency across the board. Basically driven by consumer interests: they want to know: "has my physician been sued." Consumers, or those who establish these laws, assume a correlation between malpractice

litigation and bad medical practice, this may not necessarily be the case, but that's the correlation which patients often draw, and that's what drives this sort of legislation.

The unintended consequences of that is a reluctance by physicians and hospitals to consent to settle these cases. But on the other hand, you have to look at it from their perspective. These are professionals who have trained for years. And they truly believe -- and they're often in actions wherein they truly believe they did nothing wrong.

Now, that doesn't mean they may not ultimately lose the case, because it's a jury system. But they truly believe they did nothing wrong, and they want their day in court. And they've paid their premiums to have that day in court, and they want that day in court. Just as your client, the injured patient, wants their day in court, the defendant wants their day in court.

And I think that in many cases -- in our situation, we're a physician-owned company, you're in a position where if the company feels that it's a case to settle, usually the physicians will understand why ultimately that the case should be settled. Because, the physicians will reason with one another.

I think that the genesis of the no consent requirement was really from commercial carriers who were doing it for, expediency's sake and economics' sake. Which, you know, even with large litigation, that's not usually the case, and that's not part of the claims philosophy of our company. You pay on cases that have liability and the cases that indicate departures from standard of care with causation.

So it's put us through a great deal more effort and an educational process with our insureds. But it is one of the side effects of the National Practitioner Data Bank and all of these levels of transparency. And the chances of changing that are slim and none, because they're in so many levels of government, from what I see.

WALTMAN: Ed, my understanding is that you offer policies that provide a slight discount in premiums for physicians willing to waive the right to consent to settlement.

AMSLER: Yes, a few percentage points to waive the consent.

We were required to offer that by the Insurance Department. There's never been any actuarial showing that waiving a consent-to-settle provision in a policy saves any money, but we were required to do that by the Insurance Department many years ago.

Very few doctors will accept that policy because they want to be able to control their litigation.

WALTMAN: One of the corollary questions is how deep would the discount need to be to get doctors to waive their right to consent to settlement.

AMSLER: Well, the difficulty with that, I think there's no question, you could say there may be a 90 percent discount -- but that's not really the answer, because the discount has to be related to some actuarial savings that you could document as a result. And nobody has been able to document savings as a result of it.

I mean, the discount which is offered now is just arbitrarily set by the Department in an attempt, many years ago, to incentivize its use and it requires all carriers who write this business inside the state to have it.

WALTMAN: I note that Greater New York Hospital Association offers a program to its hospitals that trains individuals health care workers how to talk with patients who have experienced an adverse outcome in order to provide full disclosure regarding the event, a meaningful apology, and an early offer of compensation, where appropriate.

CLARK: Right. The offer and disclosure policy that if you go to a patient and say, "We've made a mistake, you were injured, we would like to give you X dollars." More often than not, the patient will accept that and will not go to an attorney afterwards.

WALTMAN: Yes, it's sooner in the process than the claim stage. So it may eliminate the need for patients to ever name a physician.

A lot of hospitals are working on this approach and see the value as it relates to adverse events in general.

BIENSTOCK: It sounds to me like one common theme that I'm hearing is the market mechanisms on the insurance side aren't necessarily working the way that they should. So that

physicians, for instance, face no penalty for refusing to settle, when, if the money was coming out-of-pocket, you know, they'd be settling on Day 1 or on Day 30.

Instead, the limited hit they get, the limited hit to their reputation is all that they feel, so there's no harm in going to trial and losing. There may be some harm; I'm exaggerating. But they're not feeling the costs -- those are passed through the insurance company -- and so they can be less reasonable than they ordinarily would be in deciding whether to settle a medical malpractice claim.

And that cycles through further, in that their very premiums aren't related to any kind of market mechanisms. The insurance companies are kind of state-sponsored or mutuals that there's no profit margin in. The rates are set by the state. The physician's practices don't affect his insurance rate.

So there isn't the kind of push-back onto doctors that you might ordinarily see from the insurance companies that said, "Look, if you don't straighten out XYZ, we're going to increase your rate by 20 percent." Or "If you do ABC, you'll get a 40 percent cut." None of those mechanisms seem to be kind of working in a way, you know, where the insurance companies look to save costs by pushing back onto the doctors.

Is that observation accurate?

AMSLER: Marty, let me -- to an extent, perhaps. But let me give you some examples so that you'll understand how the system works.

We write physicians who practice good medicine, and we have peer review. If we have an insured that has multiple claims, for example, and we bring that physician in, we may find that he practices in a high-risk specialty in a high-risk position in a high-risk hospital. In which case we continue to insure that individual at manual rates. The view of this mutual has always been a broader view than just a commercial carrier.

On the other hand, if we bring a physician in that has multiple cases and we find that his standards of practice or her standards of practice are all below what we consider good medical practice, we will non-renew that physician. We can't cancel them, under state regulation, we

have to non-renew. Which means the next common anniversary date, which is July 1 of a given year, that physician is non-renewed.

If that physician cannot find cover in the voluntary market -- in other words, by going to one of the other insurers -- they have to be insured with the Medical Malpractice Pool. Now, the Medical Malpractice Pool, ironically, is comprised of a pool of all the insurance carriers who write this risk inside the State of New York, and their exposure is based upon their market share.

So we have approximately, let's say, 50 percent of the market inside New York. If we decline to write a given physician because of that physician's standards of practice and that physician goes into the pool, we are exposed to 50 percent of the exposure for that physician. That's the irony of it.

The reality, however, is that in terms of cost, the medical malpractice pool rates are approximately 300 percent higher than are the rates that are established by the Superintendent of Insurance for the regular voluntary market.

And the other aspect of it is that the voluntary market is burdened not only with those exposures but with exposures that they don't write. For example, we don't write adult-care facilities, but adult-care facilities can get insured in the medical malpractice insurance pool and we are exposed to that as well.

So, we have a lot of exposures out there which are dictated by regulation and by statute which are not voluntary exposures that the company takes on.

So yes, physicians who have been canceled can get insurance through the Medical Malpractice Pool, and the Medical Malpractice Pool is obligated to write them. They cannot turn them down. So the cover is there, but it is much more expensive.

CLARK: This is a wonderful example of how bad medical practice results in disciplining doctors, getting them out of the field. If the doctor has to pay 300 percent of his premium, he's going to be encouraged to leave the practice of medicine or go take a job someplace else.

AMSLER: You know, I tend to agree. But the reality of it is that we're doing indirectly what we should be doing directly.

I don't think that we should be using medical malpractice insurance or professional liability insurance to determine the competence of physicians. I think that's a job for somebody who has the experience, capability and capacity to make those determinations for the healthcare of the people in this state, not the malpractice insurance industry.

WALTMAN: I'd like to make a comment related to your point that the requirement to report settlements actually deters physicians from the desired goal settling. That is absolutely true in some cases. But I'd like to point out how the system as a whole acts as a deterrent to improving provider behavior.

One of the goals of the medical malpractice system, as well as the judicial system at large, is to deter unsafe conduct.

Yet, patient safety experts say that a culture of blame undermines the ability of providers to improve care. Thus, here is a disconnect between the judicial system, which by definition determines and assigns fault or blame, and what safety experts say it takes to create a culture of safety within a health care setting so that people will come forward and discuss errors so that in turn systems and behavior can be improved.

That was the underpinning of the Institute of Medicine's 1999 report: in order to improve patient safety, providers should create a culture of safety in which individuals don't get blamed for their actions. The judicial system does exactly the opposite. I recognize that the assignment of blame is at the core of the current judicial system, but that approach undermines some of the efforts of hospitals to improve care. Similarly, as you suggest, the requirement that physicians report settlements to the data bank can undermine the ability to enter early settlements.

CLARK: Well, the larger question is how can medical care be improved across the board. And we're addressing that right now with the healthcare legislation that's going on in Washington.

One of the major areas is medical fraud that doesn't involve patients or plaintiff's lawyers but the doctors themselves who own the MRI facility or who own the hospital or who own the clinic or who own the sonogram machine and who are billing -- doing these procedures in a

hundred percent of their patients and overcharging. And the New England Journal of Medicine has documented how much fraud there is within the medical field.

On June 9th in The New Yorker, Dr. Atul Gawande writes a wonderful article about how medical costs in McAllen, Texas, are twice what they are at the Mayo Clinic because the doctors own all the facilities.

I just wanted to respond to something that Susan had said, or make an observation about Susan's focus on improving quality of care as a means of reducing medical malpractice and medical malpractice costs, which I think is a special focus of hers.

AMSLER: And just to make the observation that hospitals are the one area where the two kind of come together in a financial and practical way. The hospitals are paying for their medical malpractice costs and they're providing care.

Certainly the physicians are in hospitals too, and the hospitals don't necessarily control the action of the physicians. But when you've got that commonality where you're actually providing the care and you're paying for the costs of the malpractice, you're immediately kind of focused and incentivized to provide care in a way that doesn't increase malpractice costs.

Whereas on the physician side, there's a very strong disconnect between the costs of malpractice and their actual practice. That's not to say physicians aren't doing their best to provide the top quality of care. But there's a very strong disconnect.

If a physician gets sued, it's very annoying, but he's not paying out that \$1.3 million; it's MLMIC that's doing it. And there's a lag, a very long lag between those practices and their bottom line. And, you know, I think that there's a kind of market disconnect within that insurance market that doesn't exist for the hospitals.

I think it would be much better if hospitals could get commercial insurance and would have access to that. But it is forcing the hospitals to say, "Hey, guys, wait a minute, we need to do our stuff better and improve quality and not do the things that get us sued for medical malpractice, because we can't afford it."

And that's, I think, a good dynamic that we've got, but it only covers the hospital side of the equation. And it's a complicated interplay, because the physicians are the ones who are providing the treatment.

So I just thought that was very interesting.

AMSLER: To comment on that, Marty, if I can, I think it's an error to look at this totally in terms of financial incentives and in terms of what the physician -- how much his malpractice insurance costs as it relates to the care and treatment that he renders or she renders.

Representing physicians over the years and even seeing them now in this capacity as an insurance company, these physicians out there, when they get sued, it's a sleepless-night event for them.

The relationship of physician/patient is not only a quasi-fiduciary relationship, it's one of trust and confidence. And there's a degree of pride and professionalism that they have. They don't decide what to do for a patient or what not to do for a patient on the basis of their malpractice premiums or their financials.

I recognize Bruce's point about that, but most of our malpractice cases aren't driven by unnecessary tests or ordering of tests to inure to the doctor's financial benefit.

And these good physicians who get sued and they go through trial -- and even when they win the case, they haven't won anything. They just go back to practice the next day, after the Sturm und Drang of an entire six-or-seven-year period of being a defendant in a malpractice. If you've ever been cross-examined by somebody like Bruce, you know what that feels like after two days on the stand. It is not a pleasant experience to have your entire professional capacity come into question. And anybody who's been through that once does not want to go through it twice.

So I think the physicians that I deal with and I see, very rarely do I see a financial motivation for their determination as to whether to settle a case or not to settle a case or how to proceed in terms of their practice of medicine.

BIENSTOCK: I would agree with you. And I think physicians are doing their best.

But there is that distinction. It's personal, it's not just business. And in a certain way, personal is more important. But when you think of it as business, there's much more money involved and there are more institutional reforms that might go on.

So, you know, Susan is sitting there thinking about how do we make hospitals as institutions more responsive to medical malpractice problems. And she sits there and I assume she's got, I know she's got access to people at the hospitals who sit there and worry about this day in, day out, because it goes directly to their bottom lines.

And it's a very different worry than the physician who can't sleep at night, and it affects you in different ways. But I think the drive that comes from the bottom line sometimes produces different results -- maybe better results -- than even sleepless nights do.

#### **V. No-fault Insurance for Medically Impaired Infants**

WALTMAN: As we have looked at the costs that are being incurred by hospitals in particular, we have focused heavily on the fact that approximately 35 to 50 percent of the costs of our medical malpractice coverage relates to coverage of obstetric services, a percentage that includes both coverage costs and the direct costs of certain settlements or awards. I bother to reference the direct costs of settlements and recoveries because, while many of our members carry forms of coverage, for some of our members, the cost of a settlement or recovery falls directly to their bottom line, particularly in the case of very large recoveries and settlements.

As stated, we have found that 35 to 50 percent of hospitals' medical malpractice costs relate to coverage of their obstetrics services and more particularly to cases involving neurologically impaired newborns and the costs associated with the care that they require.

At the same time, our members point to studies that demonstrate, that many of the adverse outcomes involving neurologically impaired newborns are not sensitive to medical intervention as it exists today, citing articles, for example, that have been written by Karen Nelson at the National Institutes for Health.

Those facts have led us to take the position that there should be a better, fairer way to address the costs of caring for these individuals, -- beginning with the creation of a no-fault compensation fund. Under that model, payments would be made without needing to determine

negligence or perhaps even causation. Instead, individuals with certain defined injuries would be qualified for coverage by the fund. We would thus be eliminating from the system what former Superintendent of Insurance Dinallo calls “frictional” or litigation costs and potentially providing compensation to a broader array of individuals with injuries.

The no-fault approach reduces the costs of medical malpractice coverage in two ways. First, as stated, it eliminates the frictional costs from the system. Second, depending on how it’s financed, it also can spread the cost of caring for individuals with qualifying injuries across a broader portion of society as opposed to imposing those costs only on providers delivering obstetrical care. The latter point, namely, sharing the costs of care, is important in light of the studies that indicate that providers are not able to change most of the adverse outcomes involving neurological impairment.

Having said that, I firmly believe that what must go hand in hand with a no-fault fund approach is a very concentrated effort on the part of providers to reduce those adverse events that are subject to intervention. In this regard, GNYHA has a very large perinatal safety collaborative involving its members that focuses on developing clinical guidelines as well as structures within our institutions that support perinatal safety—both because it’s the right thing to do and because the area drives a great deal of our costs.

I recognize that some people react negatively to the idea of a no-fault approach. We therefore also support a variation of a neurologically impaired newborn fund that allows cases to go through the judicial system. However, once there is a determination of responsibility through a settlement or an award, payments for the individual’s future medical care would be made from a medical indemnity fund rather than by the provider’s coverage.

Thus, there are two variations of funds that can address these enormous costs that are currently borne only by the health care system.. We would prefer the no-fault approach in order to eliminate the unnecessary costs of litigation. In addition, we underscore that the no-fault approach will compensate injured individuals more quickly and with more certainty. And, as stated, it should go hand in hand with our trying to address all of the adverse events that we can.

AMSLER: I would comment that I agree with Susan, neurologically impaired infants are a significant cost driver of our system. And it's an area where there's "thin medicine" associating many of these cases with hypoxia or anoxia or intrapartum events and/or prematurity.

And as we should look at these infants, we say: What kind of a job are we doing as a society in terms of compensating them, in terms of taking care of them? On one hand we might have an infant that has a genetic defect or is premature without any negligence and has the same disabilities as someone who has a claim that goes before a jury, and we say society compensates them at X. And then we have the one that goes through the jury system and fault is found, and society compensates them at Y because of the funding that's available -- ultimately from hospitals, mainly.

And you have to question whether or not that is the best way to be compensating these infants. Is that the way we want to be doing it, to be associating fault for some of them and no fault for others and compensating them at different levels?

And, once again, are we being efficient and timely in terms of compensation to these infants? They are a huge driver of our losses, and yet at the same time most obstetricians will tell us that, although -- admittedly, we don't have this problem down to an irreducible minimum. It's the efforts by Susan and the hospitals and physicians and obstetricians who are attempting to get all of these cases down to an irreducible minimum.

But even when you get it down to an irreducible minimum, we will still have neurologically impaired infants for which we will have a contest of experts where one says there's fault and one says there's not. Very difficult cases to win as a defendant, as you might imagine. The sympathy for these infants is monumental inside a courtroom and before the jury. And the damages awarded for future medical, future expenses are again horrendous.

And see what it does to the system. It causes a collateral exposure factor where you not only have the obstetrician sued, but you have the obstetrician's group sued, you have his or her partners sued, you have anesthesiologists sued, you have the neonatologists sued. And beyond that, we go into the hospital, who becomes a deep pocket for this exposure.

Because when you have the Appellate Division sustaining \$8 million, \$9 million for neurologically impaired infants in terms of damages, most obstetricians carry \$1.3 million in primary coverage and maybe a million dollars in excess, and so that's all that's available. So you have this bleed over into codefendants, into hospitals as a deep pocket.

And the parents of these infants who go through this process that takes years and years and years, even after the awards are determined and the money is paid, one has to ask: has that infant's life appreciably changed as a result of the monetary award? Sure, there's some change. But could it have been done in a more equitable fashion: more infants on a broader scale and in a more timely fashion? You have to ask that question.

CLARK: Very often the awards are commensurate with the horrible practice that results in the child's injury. And I feel sorry for the anesthesiologists and the other doctors who get sued, but I see it from the point of view of the child and her family, how not only is the child imprisoned in a useless body for the rest of her life, but the family is imprisoned because that child has the disability. And everybody's life, from the parents to the grandparents to the siblings to the descendants of the siblings, are all affected. And it just cries out for a large compensation if there has been negligence.

I just settled a case where the father had a video camera running for the entire period, 45 minutes after the child was born up until the child essentially died on the mother's breast, and after the mother had said to the nurse, "He seems to be twitching." The child was seizing, and the nurse left for 11 minutes.

When you see a situation like that, which is so egregious, it just cries out for some sort of punishment and compensation. And I know we don't allow for punitive damages, but what has happened to this child demands compensation. And he needs benefits for the rest of his life that other kids won't have.

Our country is 16th in the world in infant mortality. We're behind Third World countries in protecting the health of our newborns, and that shouldn't be. Let's eliminate the medical malpractice by eliminating bad malpractice.

AMSLER: Well, if I thought that the medical malpractice system in which we practice, in which our physicians practice, was truly resulting in better care for patients, I would agree with Mr. Clark.

But for as long I've been involved in this, over 30 years, I've heard that this is a great deterrent, our system is a great deterrent for bad medical practice and improves medical practice. And yet at the same time I've seen nothing but increases in frequency and increases in severity of claims. So obviously it's not working.

If this system truly is a deterrent to bad medical practice, it assumes that physicians are going to practice bad medicine unless there is a malpractice system to deter it. I don't think empirically we can demonstrate that.

And it's not so much the abandonment of the patient. How many times have we seen these cases evolve from two different experts disagreeing as to what a fetal heart monitor strip reads? And when you have an expert for a plaintiff and the sympathy factor involved in front of a jury over that, it's very, very difficult to win a neurologically impaired infant case.

And yet it's not a case of absolute black-and-white negligence where the patient's been abandoned, the infant's been abandoned on the mother's breast. These are cases where we have rational beings disagreeing about what a medical test reads, and we leave it up to a jury to make a determination as to whether or not there was negligence.

I submit to you that if you had a system where you could compensate these people, as Susan points out, these infants, no matter what that fetal heart strip read, whether you agree with this expert or you agree with that expert, I think that infant is better served under that system.

CLARK: Well, hopefully we're going to have universal healthcare so that these infants, along with everybody else in our society, or at least all other infants, will get good medical care for the rest of their lives.

You can't expect the medical malpractice system to be a cure-all for the entire system when you've got places like this McAllen, Texas, that Dr. Gawande writes about, where malpractice is not an issue. There is no malpractice litigation in Texas, and yet they have the

highest medical costs in the country and probably in the world because the doctors are benefiting, they are profiting from factors that don't necessarily result in benefits to the patient.

He gives an example of one doctor who takes out every gallbladder even though the gallbladders don't need, in most of the cases, to be removed. But he gets \$1500 or whatever it is per operation. And it's not to the patient's benefit.

WALTMAN: I'd like to go back to the fact that such a large portion of the medical malpractice costs are related to OB services. I emphasize that it is absolutely our position that individuals with neurological impairments should be compensated or covered in some way; we are very interested in ensuring that their needs are met. But given what we understand regarding the science and limits of medicine today, provider behavior during the labor and delivery process is not the reason for the impairment in most of the cases. There's no question that, as a society, we need to improve prenatal care and learn as much as we can about how to improve birth outcomes. But the point is to look at this as an area that's driving nearly half of providers' medical malpractice costs, yet the injuries involved are not, in most cases, caused by the negligence of those providers. We therefore must look at a broader, more equitable way to fund the care that neurologically impaired individuals need.

I note that as we looked at this area as part of the State's Med-Mal Task Force review process, we realized that the State's Medicaid program was already paying for the initial care—and sometimes the continuing care--of many of these individuals while they were waiting for their lawsuits to wend their way through the judicial system. We also learned that, following the resolution of the case, the local social service districts, were not uniformly recouping the outlay of Medicaid dollars under the required third party recovery process.

I emphasize that I absolutely support that there be coverage for these individuals. But, we must focus on the fact that the costs of these very large cases -- and it's the severity of cases that drives our medical malpractice costs, not the frequency of claims--directly affect hospital bottom lines. When it comes to big awards, studies indicate that one of the best predictors of whether there's a large recovery in a case is the degree of disability suffered by the plaintiff, not whether there is negligence. No where is that more true than in the area of neurologically impaired newborns.

I therefore think that, as we look at ways to reduce the costs of the medical malpractice system, how to fund the care needed by neurologically impaired newborns should be at the top of the list.

CLARK: You know, what happens in cases that go to verdict is that after the jury makes a determination, a motion is made to the trial judge saying this verdict is excessive. The defendants make a motion, if the plaintiffs win, saying the verdict is excessive and there are legal errors that should throw out the entire thing. That trial judge may reduce the verdict.

CLARK: What happens is that first there's a decision by the judge. And one of the earliest cases I had, the trial judge reduced a \$900,000 verdict to \$750,000. Then the case was appealed, and the appellate court reduced the \$750,000 to \$300,000.

I've had dozens of multimillion-dollar verdicts, and I can think of one that was not reduced when it got before the Appellate Division. So there is a control that is asserted.

## **VI. Caps on Damages for Pain and Suffering**

AMSLER: You know, caps have been bandied about for years. In 1975, during one of our early malpractice crises in this country, one of the few states that approved a cap on pain and suffering was California. And they had a cap at \$250,000 as part of their MICRA bill and have had that cap since that time.

And now there are about 30 states now that have caps in one form or another: overall caps, pain and suffering caps, whatever. These are parameters which damage awards are not allowed to exceed.

And I think it's important that we discuss that, and I think it's important for this reason. The major elements of damage in most of these cases nowadays are not pain and suffering, I think they're financial damages. They're future medical costs, they're future loss of earnings. When you look at a neurologically impaired infant, that's the case.

But yet we have the aspect of "pain and suffering" which is, you know, truly in the eyes of the jury -- as controlled by the Appellate Division and the trial judge, admittedly -- but it's been ever-increasing. In other words, that amount which is sustainable for pain and suffering.

And so when you say a cap on pain and suffering, let's say for argument's sake we have a cap of \$250,000 as in California. The rates for malpractice insurance are less than half of what they are in New York in California now. Certainly the trends in terms of tort exposure and tort liability in California are probably more liberal than they are here in New York.

So what has kept those rates down? You can't make the argument that medical care is better in California. And really we have pretty much all of the tort reforms here in New York that MICRA has, with the exception of the cap on pain and suffering.

So why is it that I think that a cap on pain and suffering really would have such a beneficial effect in terms of severity of claim? And I think California documents -- all the studies that document it indicate that it would reduce premiums. A study by Milliman indicates it's a 24, 25 percent reduction in premiums for physicians inside New York. That's really pretty much a reduction in claims costs. That's what they're saying, that claims costs are much less.

I think a cap on pain and suffering has a synergistic effect on moving cases which is analogous to the structured settlement effect. One of the great things that came about for both plaintiffs and defendants was this whole idea of being able to purchase an annuity to provide for future costs for truly injured patients. If you knew what the life expectancy was, you purchased an annuity from a life carrier and they took the risk on the life expectancy.

Any plaintiff's attorney will argue a normal life expectancy for a damaged plaintiff, and the defendant is put in the position of arguing a less-than-normal life expectancy. But by purchasing an annuity, the life carrier takes that risk and they age that plaintiff and price the annuity accordingly.

And you can argue with plaintiff's counsel over the value of the future economic loss, the value of the future medical. But in reality, usually with experienced counsel you come to a conclusion as to what those values are. And they are available on a present-day value by purchasing an annuity through a life carrier who then assumes the risk of the life expectancy.

So that's a predictable loss. And I think that's a valuable tool to getting these cases settled and having a predictable loss.

Plaintiff's counsel love it for a lot of good reasons. One, it prevents the spendthrift plaintiff from going out and spending the money on frivolous items and not protecting their future. And it protects their counsel in terms of their advice they give them and secures an income stream for the rest of their lives.

Insurance companies love it for the obvious reason that it permits them to pay present-day values with someone else assuming the risk of a life.

So if you can eliminate that aspect from the damages, the only thing that's remaining is pain and suffering. And that's really what the jury is going to evaluate and it's unpredictable.

If you cap that pain and suffering, unfortunately the cap becomes both a ceiling and a floor. Everybody will assume that their pain and suffering is worth \$250,000 and that will become a floor. And that's the downside of it.

But the upside of it is if you limited the pain and suffering to \$250,000, then you have essentially -- you've made all the damages in the case discernible, predictable, and made that case highly settleable.

And that's what happens in California. These cases move much more quickly, they move much faster, they save some money on pain and suffering. depending upon what the case is, as they lose some money when it becomes a floor as opposed to a ceiling. But the reality is that the cases of liability can move much faster because there's nothing left for a jury to make a determination on.

If it is a case where there's significant damage, you're going to pay the \$250,000, and you don't have to go through to a jury to make an award. And plaintiff's counsel is comfortable with the predictability of the future economic losses and the capped capacity of the \$250, 000.

So I think it's been proven empirically to reduce rates, it's been proven empirically to move cases faster. Of course, it has a downside. It has a downside in that you're putting limitations on recovery.

We have put limitations on tort recovery for years. In Workers Compensation we've put limitations on recovery. You know, there comes a time when society has to say enough is enough and we're going to put limitations on recoveries.

Because when you look at an injured patient and you say how much is enough, right now we're relying on juries and subsequently Appellate Divisions to control that, which has been ever-increasing for the last 30 years at astronomical proportions in terms of. As I told you earlier, it wasn't that long ago, four or five years ago, six, where a neurologically impaired sustained verdict for an infant would be \$4 million or \$5 million. Now it's \$8 million or \$9 million, and higher than that.

So I think caps on pain and suffering have a synergistic effect on moving a case faster, making it predictable, getting it settled. It does have a limitation because it does preclude a higher damage award in certain circumstances. But I think it's something that needs to be discussed.

BIENSTOCK: Is it partly because there's no objective measure to pain and suffering that you're able to set a cap on it or that you'd need a cap on it? Because unlike a lost arm, there's just no way to really measure the value of pain and suffering.

AMSLER: The difficulty with it is it's extremely amorphous and it's in the eye of the beholder.

And so much of it depends upon the plaintiff and how they can express that to a jury. I mean many plaintiff's attorneys have told me that their plaintiff is very stoic even though they have pain and suffering, but they can't express that to a jury, so therefore the award is diminished.

On the other hand, you see plaintiffs who are not as stoic and can express it to the jury very well, and their awards are much higher. Whereas, internally, those people may be suffering the same amount of pain and suffering.

So the eye of the beholder here is the jury. It's how they behold the pain and suffering and what their life experiences have meant to that. So by putting an objective standard or at least an objective limitation on it, you've eliminated that aspect.

CLARK: The trouble is that an objective limitation is not really objective. What it's doing is arbitrarily saying that everybody in the world has a maximum of \$250,000 in pain and suffering. And over and over again I see cases where somebody is disastrously injured.

I represented a woman who's now a physician who has to -- every night she has to take out a prosthesis in her mouth that covers half her upper jaw. When she eats, food comes out of her nose because she doesn't have the upper jaw.

She has no financial losses; she's probably making a million dollars a year. But to compensate her for the pain and suffering that she has every day of her life, every hour of every day of her life, \$250,000 is an insult. And to give her the same thing that you would give to somebody who has an elbow that doesn't work as well as a newborn's is unfair.

You're discriminating against the people who are really injured for the sake of some financial consideration of some corporation that insures the doctors.

WALTMAN: Whenever we have these conversations, there are always the examples that make you uncomfortable. And I respect that. There is of course always the very responsible plaintiff's attorney who only brings meritorious cases, or the case that seems to make the case for why there should not be a cap on pain and suffering.

But we must go back to the fact that we need to undertake a balancing of competing priorities in discussions about health care costs. Therefore, if you able, through a cap on pain and suffering for example, reduce 24 to 25 percent of the costs of medical malpractice coverage and there is a commitment to put those savings back into better quality care or broader health care coverage, I think it merits a very serious conversation.

Unfortunately, what typically happens, depending on the mix of party affiliations and livelihoods, is that the conversation just stops. Ed commented that there are 30 states with caps, and then you have all of these other states where you cannot even have a conversation about them.

In the end, I think we should be focusing on the broader considerations of the costs of the current medical malpractice system and better ways to apply those monies toward reducing adverse outcomes.

## **VII. Disclosure of Physician Conflicts of Interest**

CLARK: And this is my final point. I think that there would be an interim solution that would not be all-curative, but if doctors were required, as they are required to give informed consent to their patient, if one of the items that they had to tell the patient about is that “This facility that I’m sending you to, this ambulatory surgical care, happens to be owned by my wife,” it would discourage the doctor from having his own facility, and it would also discourage him in sending every procedure to his wife’s facility.

So I think if there were required disclosure of conflicts of interest, it would cost nobody anything to do it. All it would take is the doctor would say “It happens that I own 1/100th of this facility, and I’m telling you about it, you can make your choice whether to go there or not or stick with me as a physician,” and have the patient sign off on it. And then maybe allow that to be a subject of cross-examination if malpractice subsequently occurs and the allegation is the doctor did an unnecessary procedure that injured the patient.

I think the disclosure of conflicts of interest will result in a lot fewer procedures that are unnecessary. And I think it’s paradoxical that if the doctors are not compensated, they will probably work less and practice better medicine.

I also thought that early settlement is a way to contain medical expenses. In the beginning of my career, I worked for a law firm that defended cases for two different insurance companies. One of them would seek out the plaintiffs at the earliest stages, as soon as they knew what the case was about, and settle the case. The other insurance company would take everything to verdict. And the first insurance company, to my observation, was paying about 50 percent of what the other one was, because they got rid of the cases in a hurry.

And I think it’s incumbent upon -- and I think it’s happening that we are starting to settle cases more early with the mediation process, that when the insurance company and the physicians realize that they’ve got a case of liability, mediation is initiated. And we all know that we want to settle the case, the plaintiff wants to settle the case, and cases are disposed of and medical costs are reduced.

BIENSTOCK: My sense is there's a consensus that if we can move the settlement process more quickly, both plaintiffs and defendants would benefit. That there are -- I wouldn't want to call it wasted costs in the system, because I don't want to criticize anyone, but there are costs that we could save in the system by moving up, you know, the settlements. And there are various proposals that have been built around that.

And, you know, neither side is eager to give anything, so it's hard to come up with a solution that doesn't disadvantage one side or the other. But I think everyone's agreed on let's settle these things earlier rather than later; it saves money. And I think that's a very valuable contribution.

AMSLER: I don't disagree with that at all.

WALTMAN: Many of the hospitals with which I work subscribe to that approach and have undertaken a number of initiatives to encourage early resolutions, including, as indicated, training people to provide full disclosures, meaningful apologies, and early offers of compensation. It's of course the right thing to do and it also has a favorable cost impact for the provider and the system. Many are also doing a more aggressive job of managing and moving claims more quickly.

I refer back to some of the tools that can facilitate the decision-making or resolution process, such as expert depositions. While I don't want to begin that conversation again, hospitals will say they sometimes need more information to make decisions regarding settlement offers. But they all are trying to identify ways to manage claims better, ensure fair payments, and reduce their costs.

AMSLER: One of the struggles you have is the -- I guess the category is "I'm sorry" legislation. Most states that have "I'm sorry" legislation have immunity attached to it. So it lets the provider -- the hospital, the nurse, the physician, whomever -- come in and express remorse, apology, sympathy, empathy, et cetera, and be immune from that coming out at the time of trial.

If you do it without that, there's going to be a natural reluctance on the part of a potential defendant to have these discussions.

And I agree that early settlement is certainly indicated. One of the problems you have is just a basic -- with HIPAA, with all the problems you have getting records, you have some basic hurdles to overcome: multiple codefendants, getting all the records, getting analysis, getting experts. These things take some time. And in fairness to both parties, they do take time.

The plaintiff has some time, assuming the statute of limitations isn't at issue, they have some time to do their investigation. The defendants and the insurance carrier both sit down when the first notices, the summons is served, and then you've got to start your process of evaluating it. It's a difficult process of evaluating, to get all the records, etc.

But once you do that, I agree with Bruce when he says that mediation is effective. When we have experienced plaintiff's counsel and we have control of the defense and it's a case that we want to settle and we can sit down with an experienced mediator, we have had great results getting cases settled. Because it loses the posture of very high demands, very low offers. We get into a room with experienced plaintiff's counsel, where they understand the value, we understand the value of the case, and these cases get moved.

And we've done that without any legislation, without any regulation. We've done that on our own by cooperation among plaintiff's counsel, by some very effective mediators, and cooperation from insurers.

### **VIII. Concluding Remarks**

WALTMAN: Marty, as you know from the State's Medical Malpractice Task Force meetings, I always started and I guess ended with the statement that the most important thing we can do as providers is to provide safe care and reduce adverse outcomes. I don't want to lose track of the responsibility that we, as providers, have. We are working hard to do that and are very cognizant of the areas on which we need to concentrate.

At the same time, our current system for resolving disputes is unreasonably costly, and the nation is looking very hard at how to reduce the cost of health care.

Therefore, we need to do what we can to try to improve the dispute resolution process and to reduce the costs of the system. That means that everyone needs to step back from the predictable political positions that we take. In the end, the health care system and our patients

should be the focus, and we need to be open to changing the rules and the system for the benefit of all of us.

AMSLER: No, I just wanted to say, from my perspective, we're dealing with the physician/patient relationship. And that's a one-on-one relationship that society has always recognized.

And the whole issue of malpractice and professional liability is an issue which has come between those two people, the physician and the patient, and it's got an ever-increasing presence in that relationship -- everything from money, to reimbursement, to discussion, to discourse between the two of them, to the treatment that's rendered. And we've got to do our best to minimize that, to minimize its presence in that relationship, the inherent sense of fault, the inherent sense of somebody doing something to someone as we exist in this increasing litigious climate.

And anything that we can do, whether it's mediation, whether it's mandatory arbitration, whether it's "I'm sorry" and immunity, things that will bring the physician/patient back to a relationship of trust and confidence -- as opposed to one in an adversarial position which is driven not only financially but by impediments to that relationship -- I think it will serve the bar well, and I think it will serve the physicians and the patients well.

CLARK: I agree with Susan and Ed that our primary concern should be the welfare of the patients and to encourage the best medical practice that is possible.

Malpractice is a very small element of the cost of medical care, maybe 1 percent overall. One of the problems is that when doctors have the profit motive, that comes between them and the patient more than anything else. And in jurisdictions where they do not have malpractice anymore, the profit motive is causing the doctors to do procedures that are unnecessary, to practice what has been called defensive medicine and blamed on us as attorneys, but we're finding that defensive medicine turns out to be profitable medicine.

And ultimately, hopefully, the whole medical system is going to be revamped where doctors do not have a financial incentive to treat the patient but only to do the right thing and that the facilities will be made available for them to do the right thing. I think one of the biggest

things is for doctors to not be private practitioners but to be members of corporations, where they're getting paid by capitation rather than by what they do, paid per patient that they treat, encouraged to treat the patient at the earliest level, to do preventive medicine, prevent the cancers while they're still coming out of the smokestack, to diagnose early before the costs of medical care escalate and when the things can be treated most effectively, as opposed to at the end when the patient is riddled with cancer and they get a quarter of a million dollars' worth of radiation that probably isn't going to do them any good.

So what we've got to do is structure medical practice so that the patient's interests are paramount and that there are not influences such as the doctor's profitability that enter into it.

BIENSTOCK: I thought one interesting facet that kept reappearing was the difference between looking at this from an individual perspective – doctor, patient, treatment, duty, breach, damages -- and looking at this from a social perspective: what are our hospitals about, who's bearing the ultimate costs of this, is there a more efficient way of bearing these costs.

And those are I think conflicting ways of looking at this that get you to very different results. And I'm not sure that that's something that's easily resolved.

If you're a patient who's been victimized, you want a certain type of result to come out, you want to be paid for your damages. And you're entitled to be, from that perspective.

From a social perspective, it really doesn't make that much sense that two neurologically impaired infants -- one who might have suffered from some element of malpractice, and one who didn't -- will be treated very differently through our compensation system.

So two different ways of looking at it produce two very different results, and I'm not sure they can be resolved. But I think we did a lot to flesh out those issues and some of the others.