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GEORGIA'S PATIENT COMPENSATION SYSTEM – A NEW STATE AGENCY THAT WILL HARM PATIENTS

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A draft bill is circulating in Georgia entitled the Patient Injury Act. It proposes to replace Georgia's civil justice system in medical malpractice cases with a new government agency called the Patient Compensation System. All patients would be forced into this government system with no ability to opt out.

Some of the ideas behind the Patient Injury Act are not new. This "alternative government tribunal" idea is in many ways similar to a proposal known as "health courts," about which there has already been a great deal written. One of the precepts of conservative economic theory, which these proposals violate, is that the tort system's economic function is deterrence of non cost-justified accidents, with the tort system creating economic incentives for "allocation of resources to safety."¹ Both systems would do away with the tort system in medical malpractice cases, replacing it with government regulation of what is now a free-market approach to holding health care providers accountable for their negligence.

Both systems would abolish judges and juries as fact-finders in medical malpractice cases, in violation of Georgia's Constitution.² Every aspect of a medical malpractice adjudication would be controlled by a new state agency, including the establishment of new liability standards for physicians. Health courts at least propose using specialized "judges" instead of political appointees and government bureaucrats pulled directly from the medical and business establishments as the Patient Injury Act requires. But in all cases, these decision-makers would be unanswerable to the common law already established by centuries of Georgia court decisions. Georgia physicians would have to abide by future standards dictated by this government agency.

Both proposals would institute an "avoidability" standard for liability, which is a fault-based standard. Both proposals would use dictatorial compensation schedules established by a government agency for at least some kinds of damages, although the Georgia proposal would use

¹ See, e.g., William M. Landes and Richard A. Posner, *The Economic Structure of Tort Law*. Cambridge, MA: Harvard University Press (1987).

² *Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt*, 286 Ga. 731 (2010), <http://www.gasupreme.us/sc-op/pdf/s09a1432.pdf>.

such schedules for all damages. In Georgia, compensation would be further limited by an overall fiscal cap even though bringing more patients into the system – a social engineering goal outside the free market tort system, which proponents say they want to accomplish – would involve substantial increases in total direct malpractice costs. That only means one thing: dramatic reductions in recoveries for the most seriously injured patients to levels well below their actual losses, likely forcing them onto other government health and disability programs, such as Medicaid. Compensation for medical injuries, especially for the most seriously hurt, as well as for lost wages and non-economic damages, would be severely capped in violation of Georgia’s Constitution,³ if even allowed.

Under both systems, the tort system’s linkage between harm done and compensation paid would be either weakened or eliminated, interfering directly with the tort system’s free market deterrence function. Even worse, proponents assert that the Georgia proposal would keep malpractice payments from being reported to the National Practitioner Data Bank, the national databank of physician malpractice and disciplinary records on which hospitals rely in making hiring decisions, which is one of the most important sources of patient safety information in the nation. If the proponents’ assertion is correct, the result is that this proposal would turn the state of Georgia into a safe harbor for incompetent physicians and an attractive place for such physicians to relocate. In other words, from a patient safety perspective, the Georgia proposal is appalling.

Both systems have strong public relations spins attached to them, promising a more fair and reliable system of resolving medical malpractice claims, as well as reducing costs. However, the provisions themselves expressly contradict these articulated objectives. In fact, because these systems would remove the entire proceeding from the jury system while giving patients little in return and in some cases harming them, these proposals raise serious constitutional concerns. Their wholesale dismissal of the jury system, the creation of an entirely new state governmental agency to handle what are a relatively small percentage of cases in our court system⁴ and the likely costs of maintaining such a system⁵ are why health courts have gone nowhere in Congress or in any state in the nation.

Some advocates for the Georgia proposal suggest that it is needed for the citizens of Georgia because the malpractice system delivers compensation too slowly and is too expensive. To anyone who truly is concerned about those problems in the current system, it is worth noting that nothing today prevents providers or liability carriers from settling legitimate claims with patients before they file a court case or from paying valid claims expeditiously. In fact, CJ&D and the malpractice victims with whom we work all agree that informal pre-trial settlements, where both parties voluntarily agree to take a case out of the civil justice system, are not only appropriate but

³ *Ibid.*

⁴ Medical malpractice cases account for only about 9 percent of all civil cases disposed of by trial in state courts. U.S. Department of Justice, Bureau of Justice Statistics, “Civil Bench and Jury Trials in State Courts, 2005,” NCJ 223851 (October 2008) (revised April 9, 2009) at 2 (Table 1), <http://www.prisonpolicy.org/scans/bjs/cbjtsc05.pdf>.

⁵ Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 72. (“[C]laims involving error account for at least 84 percent of total system costs ... so that, even if we assume that only claims involving error are brought into the system, the system costs should increase by a factor of at least 28, all other things (like system efficiency) being equal.”) See, “The Costs of Alternative Tribunal Systems are Significant, Especially When Including Non-Negligence Claims,” *infra*, p. 8.

currently resolve the vast majority of legitimate medical malpractice claims today.⁶ However, mandatory and binding statutory schemes like this one, which rely on entirely new state agencies, tilt the legal playing field dramatically in favor of the health care industry, eviscerate the jury system and patients' rights to adequate compensation, disrupt the settlement process⁷ and protect the most incompetent physicians – are deplorable.

PATIENTS FORFEIT SIGNIFICANT RIGHTS FOR LITTLE IN RETURN

This proposal would eliminate the right to trial by jury for anyone injured by medical malpractice. It replaces unbiased judges and juries with a new state governmental agency, the vast majority of whose members are from the medical and business establishments. It should be noted that even in alternative systems where decision-makers are “neutral,” administrative tribunals do not offer protections for plaintiffs provided by the court system to counterbalance disparities between parties, *e.g.*, procedural and substantive rights like the right to know and rebut evidence through discovery, cross-examination and argument, civil rules of procedure and an impartial judge who is guided by substantive law.

But obviously, there is nothing “neutral” about the decision-makers envisioned here. The bias is intentional and explicit. All liability and compensation decisions would be determined by a string of political appointees and/or government bureaucrats, a majority of whom *by law* must represent the medical and business establishments. One of the jury's most important functions – determining damages after listening to both sides in a case – is brushed aside in favor of yet undetermined “compensation schedules” written or approved by these individuals. Whatever compensation they would allow is completely discretionary on their part. All that seems certain is that some sort of “one-size-fits-all” schedule will be developed – so much for an eye, so much for a leg, so much for a dead child and so on. The only thing the law specifies is the requirement of fiscal-related limits to the overall compensation schedules – *i.e.*, absolute “caps” – based on overall costs irrespective of patients' needs.⁸

⁶ In the Harvard closed claims study, 15 percent of claims were decided by trial verdict. David M. Studdert et al., “Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,” *New England Journal of Medicine*, May 11, 2006, <http://www.nejm.org/doi/full/10.1056/NEJMSa054479>. Other research shows that 90 percent of cases are settled without jury trial, with some estimates indicating that the figure is as high as 97 percent. Testimony of Neil Vidmar, Russell M. Robinson, II Professor of Law, Duke Law School before The Senate Committee on Health, Education, Labor and Pensions, “Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients,” June 22, 2006, at 17 (citations omitted), <http://www.help.senate.gov/imo/media/doc/vidmar.pdf>.

⁷ According to Neil Vidmar, Professor of Law, Duke Law School, “Without question the threat of a jury trial is what forces parties to settle cases. The presence of the jury as an ultimate arbiter provides the incentive to settle but the effects are more subtle than just negotiating around a figure. The threat causes defense lawyers and the liability insurers to focus on the acts that led to the claims of negligence.” Testimony of Neil Vidmar, Russell M. Robinson, II Professor of Law, Duke Law School before The Senate Committee on Health, Education, Labor and Pensions, “Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients,” June 22, 2006, at 21, <http://www.help.senate.gov/imo/media/doc/vidmar.pdf>.

⁸ 15-13-4, Section (d)(5)(B) states, “The Compensation Committee shall in consultation with the chief compensation officer, recommend to the board: (i) A compensation schedule formulated such that the initial compensation schedule plus the initial amount of contributions by provides shall not exceed the prior fiscal year aggregate cost of medical malpractice as determined by an independent actuary at the request of the board. In addition initial damage payments for each type of injury shall be no less than the average indemnity payment reported by the Physician

The proposal resembles other government systems where victims have ceded their right to trial by jury based on some kind of promise, but where that promise is ultimately broken due to influence-peddling and future budgetary/solvency considerations that no lawmaker today can control. There are many examples of this occurring, including: workers' compensation,⁹ the fiscal problems of which are typically solved by reducing benefits and increasing obstacles for workers; the federal Vaccine Injury Compensation Program, which tries to reduce costs by fighting parents who try to get in the system;¹⁰ and Virginia's Birth-Related Neurological Injury Compensation Program.¹¹

However, at least those systems offer patients care in exchange for not having to prove fault. For example, Virginia's Birth-Related Neurological Injury Compensation Program was set up in the

Insurers Association of America or its successor organization for like injuries with the like severity for the prior fiscal year. Thereafter, the Compensation committee shall annually review the compensation schedule, and, if necessary, recommend a revised schedule, such that a projected increase in the upcoming fiscal year aggregate cost of medical malpractice, which shall include insured and self-insured providers, shall not exceed the percentage change from the prior year in the medical care component of the consumer price index for all urban consumers.”

⁹ Without belaboring in extreme detail the problems pervading workers' compensation systems, it is widely accepted that this system has over the years worked more and more poorly for the permanently disabled, those most analogous to the participants who would be most hurt by the Georgia proposal. Permanently disabled workers today do not receive enough compensation and the compensation duration is too short as states chip away at these benefits in direct response to pressure from insurance carriers and businesses. In many states, the process workers must go through to make claims and receive compensation has become longer, less efficient and ultimately less successful in terms of its original goals. See, “Worker’s Comp: Falling Down on the Job,” *Consumer Reports* (2000)(discussing the legislative reforms of the 1990s and the resulting profits for workers' compensation insurance providers); Rand Research Brief, “Compensating Permanent Workplace Injuries” (1998). According to one legal scholar who studied workers' compensation, “injured workers often face denials and delays of apparently legitimate claims, high litigation costs, discrimination, and harassment by employers and coworkers.... [M]any reports suggest that recent reforms have substantially increased injured workers' financial burdens.” Martha T. McCluskey, “The Illusion of Efficiency in Workers' Compensation “Reform,”” 50 *Rutgers L. Rev* 657, 670-671, n. 34, 35 (1998). In sum, having ceded their right to jury trial at a time when the law would have left most of their injuries uncompensated, these workers now face serious disadvantages relative to those with access to the judicial system. See, Center for Justice & Democracy, *Workers' Compensation – A Cautionary Tale* (2006), [http://centerjd.org/lib/Workers'Comp\(NY\).pdf](http://centerjd.org/lib/Workers'Comp(NY).pdf).

¹⁰ See, Amy Widman, “Why Health Courts are Unconstitutional,” 27 *Pace L. Rev.* 55 (Fall 2006), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1856042 (The Vaccine Injury Compensation Program was created by federal statute in the mid-1980s. National Childhood Vaccine Injury Act of 1986, P.L. 99-660. As originally contemplated, if you or your child receives a covered vaccine and then presents a covered injury from the vaccine, you or your child is entitled to compensation. However, as this law's implementation has been modified by new political forces, extreme problems with access and compensation for victims have developed. Although originally proposed as a no-fault model that would be efficient and provide for quick compensation, many experts say that the program has been co-opted by political forces and turned into a victim's nightmare. See, Elizabeth C. Scott, “The National Childhood Vaccine Injury Act Turns Fifteen,” 56 *FOOD & DRUG L.J.* 351 (2001)(stating that, as of 2001, 75 percent of claims were denied after long and contentious legal battles taking an average of 7 years to resolve). See also, Statement of the National Vaccine Information Center Co-Founder & President Barbara Loe Fisher, House Oversight Hearing, “Compensating Vaccine Injury: Are Reforms Needed?” September 28, 1999 (discussing the unilateral power HHS has to change the burdens of proof and other restrictions); Derry Ridgway, “No-Fault Vaccine Insurance: Lessons from the National Vaccine Injury Compensation Program,” 24 *J. HEALTH POL'Y & L.* 59, 69 (1999)(describing how the program originally awarded many more claims, until the Department of Justice decided to aggressively argue against claimants.)

¹¹ This plan has been in fiscal crisis for years. See, e.g., Bill McKelway, “Decision rejects payments to lawyers for hospital, doctor in birth-injury case,” *Richmond Post Dispatch*, December 20, 2012, <http://www2.timesdispatch.com/news/2010/dec/20/tdmet01-decision-rejects-payments-to-lawyers-for-h-ar-726430/>

1980s as a *no-fault* injury compensation system for babies born with neurological injuries, whether or not the injury could have been “avoided.”¹² As one commentator explained, “by giving up their right to bring suit, families were promised lifelong medical care for eligible children.”¹³ But even these promises have been broken. Specifically, children and their families “have been forced to absorb stunning disparities in program benefits because of shifting priorities and cost reductions over which they had no control or voice. . . . ‘The program can end up providing very little,’ said Christina Rigney, referring to the minimal benefits her family received in the face of her son’s traumatic birth and brief life.”¹⁴ Given the overall fiscal cap required by the Georgia proposal, and the goal of providing a larger number of injured patients with compensation, it is clear that successful claimants with the most serious injuries requiring a lifetime of care would receive far less compensation than under the traditional tort system or at a level that their actual losses would suggest.

Further, the law gives political appointees and their hired guns complete discretion to not only limit certain kinds of damages, but conceivably, to wipe them out entirely. Other than the overall fiscal cap, there are no legislative guidelines for determining allowable medical compensation for future medical care, lost wages, lost earning capacity, non-economic damages and so on, making certain that they will either be capped or, in some cases, completely eliminated. What’s more, when it comes to someone who is catastrophically injured or has a child in this situation, the goals of speed and efficiency touted in the legislation actually could have devastating consequences. The future medical needs of someone with serious complications, such as a brain-injured newborn, might not be known for some time. What difference does it make if a child’s family obtains predetermined “capped” funds in 60 days if it means they will be shortchanged for the next 50 years? Any notion that this proposal contemplates fairness when it comes to compensating such patients is absurd.

These hardships on patients are then coupled with the burden of having to prove fault. The standard is called “avoidability” and appears to draw from a standard applied in Sweden. This is not a “no-fault” standard. As Law Professor Amy Widman has written, “An avoidability

¹² Section 38.2-5001, Code of Virginia states: “‘Birth-related neurological injury’ means injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation necessitated by a deprivation of oxygen or mechanical injury that occurred in the course of labor or delivery, in a hospital which renders the infant permanently motorically disabled and (i) developmentally disabled or (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled. In order to constitute a ‘birth-related neurological injury’ within the meaning of this chapter, such disability shall cause the infant to be permanently in need of assistance in all activities of daily living. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality, degenerative neurological disease, or maternal substance abuse. The definition provided here shall apply retroactively to any child born on and after January 1, 1988, who suffers from an injury to the brain or spinal cord caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post delivery period in a hospital.”

¹³ Bill McKelway, “Plan could restore financial soundness,” *Richmond Times Dispatch*, September 17, 2007, <http://www.accessmylibrary.com/article-1G1-168746532/plan-could-restore-financial.html>.

¹⁴ Bill McKelway, “Danville Has High Birth-Injury Rate; Critics Say Virginia Law Shields Doctors from Lawsuits,” *News Virginian*, June 1, 2003.

standard contemplates some element of fault in that there is a judgment that care was somehow sub-optimal and this lower level of care resulted in injury.”¹⁵ Moreover,

[C]ontrary to many glossy press releases, the same people designing the current [health court] model and often describing it as “no-fault” have written in legal journals that “the tag ‘no-fault’ is somewhat misleading because the central notion of ‘avoidability’ is actually interpreted quite differently.” In studying the results of Sweden’s avoidability standard, it is clear that this standard creates a higher standard for compensation than no-fault. In addition, similar studies have found a “non-trivial failure rate of claims” under this approach.¹⁶

That is certainly contemplated here, as the Georgia bill gives providers the right to fight patients’ claims and appeal any finding against them to the medical establishment representatives who are appointed to judge the patient’s claim.

Where there are power and resource disparities between the parties, requiring patients to prove “avoidability,” causation and other issues before a state agency – even one that did not rely upon health care professionals as decision-makers – is extremely unfair to the patient. This is particularly true in the context of medical malpractice actions because the disputing parties are extremely ill-matched. The parents of catastrophically injured children, who are in need of medical care, who are disabled or perhaps in pain and who may have major medical expenses, are in a substantially weaker position than the medical establishment. Representation by a competent attorney fighting for them is critical. This is not a minor point. As the Harvard School of Public Health, which studied this country’s medical malpractice system, reported, “our findings underscore how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information that litigation triggers.”¹⁷

It should be noted that the first three “legislative findings” of the proposal feign concern that patients often cannot find counsel to represent them. It then goes on to construct a system where no patient will likely have counsel, while being forced to prove the provider’s fault in a system where the provider is given every opportunity to fight the patient, aided by their own high-priced attorneys at every step.¹⁸ One of the more ridiculous elements of the proposal is that the personnel running the Patient Compensation System, who make all liability and compensation decisions, are also given the power to hire an “advocacy director” ostensibly for the patient. This individual, picked by a panel heavily weighted toward industry, is to “determine” if the patient needs an attorney to fight not only the provider but also the state Patient Compensation System itself. Even in the unlikely event this is recommended (and assuming an attorney could be found who would even be qualified), the system still goes forward whether the patient is represented or

¹⁵ Amy Widman, “Why Health Courts are Unconstitutional,” 27 *Pace L. Rev.* 55, 61 (Fall 2006), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1856042.

¹⁶ *Id.* at 60 (citations omitted).

¹⁷ David M. Studdert et al., “Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,” *New England Journal of Medicine*, May 11, 2006, <http://www.nejm.org/doi/full/10.1056/NEJMsa054479>.

¹⁸ See, Philip G. Peters, Jr., “Health Courts?” 88 *B.U. L. Rev.* 227 (2008), <http://www.bu.edu/law/central/jd/organizations/journals/bulr/documents/PETERS.pdf>.

not. It should be obvious to anyone that this presents a conflict of interest that is highly unfair to the patient. This is a travesty for patients.¹⁹

CONSTITUTIONAL PROBLEMS

When a legislature attempts to strip away the right to jury trial and remove a common law cause of action from the civil justice system, the courts insist that those ceding their rights receive something sufficient in return, an adequate “quid pro quo,” or trade-off, for losing constitutional rights. Here, the promise is that an alternative system will be more speedy and cheaper, although as noted above, for seriously injured victims whose future medical needs may not be known for months, a quick and cheap resolution of their case via compensation schedules may be extraordinarily harmful to them.

Schedules like those proposed in the Georgia bill eliminate any room for consideration of circumstances for injuries, which judges and juries – not politicians or bureaucrats – are uniquely qualified to evaluate after hearing all the evidence in a case. As pointed out in 2006 congressional testimony by Duke Law Professor Neil Vidmar, “Even when some leeway is built into compensation schedules, they cannot take into account the number of factors and extreme variability of ... damages. That is why these matters have been entrusted to juries. They provide justice on an individualized basis.”²⁰

This was made clear by the Georgia Supreme Court, which in 2010 struck down a far more subtle intrusion into the jury system – a “cap” on non-economic damages, citing decades of authority and precedent.²¹

The Georgia Constitution states plainly that “[t]he right to trial by jury shall remain inviolate.” Ga. Const. of 1983, Art. I, Sec. I, Par. XI (a). ...

As with all torts, the determination of damages rests “peculiarly within the province of the jury.” (Citation omitted.) *Dimick v. Schiedt*, 293 U. S. 474, 480 (3) (55 SC 296, 79 LE 603) (1935). See also OCGA § 51-12-12 (a) (“[t]he question of damages is ordinarily one for the jury”). Because the amount of damages sustained by a plaintiff is ordinarily an issue of fact, this has been the rule from the beginning of trial by jury. See Charles T. McCormick, *Handbook on the Law of Damages* § 6, p. 24 (1935). See also 3

¹⁹ Professor Peters called the combination of anti-patient provisions in health court proposals, “a physician’s utopia. Juries would be replaced by specialized administrative law judges, contingent fee plaintiff’s attorneys would be replaced by agency attorneys who would screen out the ‘frivolous’ claims, and full compensation for negligently injured patients would be replaced with highly restricted damages. Because it was so one-sided, the AMA proposal attracted little support...” Philip G. Peters, Jr., “Health Courts?” 88 *B.U. L. Rev.* 227 (2008), <http://www.bu.edu/law/central/jd/organizations/journals/bulr/documents/PETERS.pdf>.

²⁰ Testimony of Neil Vidmar, Russell M. Robinson II Professor of Law, Duke Law School, before the U.S. Senate Committee on Health, Education, Labor and Pensions, “Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients,” June 22, 2006, at 18 (citations omitted), <http://www.help.senate.gov/imo/media/doc/vidmar.pdf>.

²¹ *Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt*, 286 Ga. 731 (2010), <http://www.gasupreme.us/sc-op/pdf/s09a1432.pdf>.

Blackstone, Commentaries, supra, Ch. 24, p. 397 (“the quantum of damages sustained by [a plaintiff] cannot be [ascertained] without the intervention of a jury”). Hence, “[t]he right to a jury trial includes the right to have a jury determine the amount of . . . damages, if any, awarded to the [plaintiff].” (Emphasis in original.) Feltner v. Columbia Pictures Television, Inc., 523 U. S. 340, 353 (III) (118 SC 1279, 140 LE2d 438) (1998). Accord Western & Atlantic R.R. v. Abbott, 74 Ga. 851 (3) (1885) (pain and suffering damages to be measured according to enlightened conscience of impartial jurors). . . .

The very existence of the caps, in any amount, is violative of the right to trial by jury.... [and] violate[s] the right to a jury trial as guaranteed under the Georgia Constitution.

In examining analogous health court proposals, Professor Widman writes, “Proponents of the health court models quickly play down the lack of juries in the new system by citing to worker’s compensation. It is not a fair analogy. Worker’s compensation is a no-fault scheme. This is the compromise the courts have upheld. If there is no fault to be litigated, then an alternative administrative tribunal is not as troubling. The determination of fault is the quintessential jury function.”²² In other words, in other systems, “the trade-off is clear: remove the dispute from the jury but relieve the plaintiff of the burden of proving fault. The plaintiff is left with guaranteed compensation if certain conditions are met.”²³ None of that is true here. In fact, like health courts but perhaps even more so, the Georgia proposal “stacks the process against the plaintiff. More importantly, the fault standard means that there is no reasonably just substitute for removing the common law claims from civil courts with juries. The token benefits being offered to offset the serious breach of individual liberty are neither factually nor legally sufficient.”²⁴

Given the magnitude of what would be taken away by the Patient Injury Act – rights firmly established in Georgia’s Constitution and recently unanimously reaffirmed by the state’s highest court – patients are clearly getting little in return and many will be worse off. This proposal is plainly unconstitutional.

THE COSTS OF ALTERNATIVE TRIBUNAL SYSTEMS ARE SIGNIFICANT, ESPECIALLY WHEN INCLUDING NON-NEGLIGENCE CLAIMS

In October 2009, the Congressional Budget Office (CBO) scored the impact on health care costs of a number of severe “tort reforms,” including a \$250,000 cap on non-economic damages, which is unconstitutional in Georgia. It found that even if the country enacted the entire menu of extreme tort restrictions, it could go no farther than to find an extremely small percentage of health care savings, about 0.5%,²⁵ “far lower than advocates have estimated.”²⁶

²² Amy Widman, “Why Health Courts are Unconstitutional,” 27 *Pace L. Rev.* 55, 64 (citations omitted)(Fall 2006), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1856042.

²³ *Id.* at 75 (citation omitted).

²⁴ *Ibid.*

²⁵ Congressional Budget Office, “CBO’s Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice (‘Tort Reform’),” October 9, 2009, <http://www.cbo.gov/publication/41334>.

²⁶ Alexander C. Hart, “Medical malpractice reform savings would be small, report says,” *Los Angeles Times*, October 10, 2009, <http://articles.latimes.com/2009/oct/10/nation/na-malpractice10>.

Neither “health courts” nor similar state government tribunals, such as the system envisioned by Georgia’s proposal, have been “scored” by CBO. Indeed, no credible analyst believes removing the relatively few medical malpractice cases that now proceed through the civil justice system and instituting a new government agency to handle them is a money-saver. This is especially true if the system is fault-based,²⁷ as is the Georgia proposal, and if proponents are taken at their word – that is, they want to achieve a social engineering goal, outside the free market tort system, by compensating more patients. As Case Western Reserve Professors Maxwell J. Mehlman and Dale A. Nance noted in their book *Medical Injustice: The Case Against Health Courts* (2007), “The Republican Policy Committee states, for example: ‘The health court proposal is not about reducing costs overall (since many more people may be compensated at smaller amounts).’”²⁸ These authors made the following additional observations:

- Health courts “would entail some huge potential increases in total system costs.... If we take health care proponents at their word, their goal is to bring ... currently non-claiming people into the process.” This, however “would multiply the number of claims involving negligence by a factor between 33 and 50.”²⁹
- “[C]laims involving error account for at least 84 percent of total system costs ... so that, even if we assume that only claims involving error are brought into the system, the system costs should increase by a factor of at least 28, all other things (like system efficiency) being equal.”³⁰
- “[E]ven if we assume that the average per patient damages under a new system embracing all potential claimants (including those who claim under the existing system) would be only 30 percent of the average damages for claims now paid, that still leaves total direct system costs multiplied by a factor of about 8.5, again as a low end estimate.”³¹
- Health courts involve the creation of a new judicial or administrative bureaucracy. Costs “would certainly be substantial, vastly more than the public (taxpayer borne) judicial costs currently associated with the adjudication of malpractice claims.”³²

²⁷ See, Philip G. Peters, Jr., “Health Courts?” 88 *B.U. L. Rev.* 227, 260 (2008),

<http://www.bu.edu/law/central/jd/organizations/journals/bulr/documents/PETERS.pdf> (“No-fault systems, such as workers’ compensation insurance, drastically reduce administrative costs because they eliminate the need to prove or defend against allegations of fault. ... Fault-based systems, by contrast, must provide both parties with a fair opportunity to explore the strengths and weaknesses of the claimed breach of duty. Any attempt to produce the economies found in no-fault disputes within a fault-based claims system will inevitably increase the risk of unjust verdicts.”)

²⁸ Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 74.

²⁹ *Id.* at 72.

³⁰ *Ibid.*

³¹ *Ibid.*

³² *Id.* at 73.

ADDITIONAL INACCURACIES AND MYTHS IN THE LEGISLATIVE FINDINGS

Findings 4, 5 and 6 of the Patient Injury Act discuss national policy points suggesting that an “overwhelming majority of physicians practice defensive medicine because of liability exposure” and that these “unnecessary tests” drive up the cost of health care and expose patients to “unnecessary clinical risks.” In addition, say proposal proponents, there is an “overwhelming public necessity” to recruit physicians, which this program will solve. None of this is true and in fact, under this proposal, the only physicians that will be attracted to Georgia are incompetent physicians who wish to avoid having their malpractice record turned over to the invaluable National Practitioner Data Bank.

Defensive Medicine

The defensive medicine argument is not only wrong, but it is belied by the nature of the fault system that the Patient Injury Act sets up. The entire rationale behind “defensive medicine” is that by eliminating lawsuits, doctors will not have to think about liability anymore. But because this is a fault-based system, and physicians can still theoretically be disciplined by state boards, the entire “defensive medicine” argument is completely undercut. Certainly, liability standards determined by the government provide no more meaningful guidance to practitioners about what constitutes appropriate patient care than what could be available from records of jury verdicts, judgments and settlements.

But let’s assume the entire argument is not undercut by the nature of the Patient Injury Act. Many experts have said that there are no reliable data showing widespread existence of this extremely ill-defined practice or certainly that liability considerations (as opposed a patient’s best interests) are ever the exclusive reason why most tests and procedures are performed.

To begin, numerous studies have debunked the notion that health care costs can be saved by stripping away patients’ legal rights. In over 30 years, medical malpractice premiums and claims have never been greater than 1% of our nation’s health care costs.³³ Despite this, the claim is often made that these figures do not include the costs of so-called “defensive medicine,” or the ordering of tests or procedures to avoid litigation and not because they are “medically indicated and necessary for the health of the patient,” as required by Medicare.³⁴ However, as noted above, in its October 2009 analysis, CBO found that even if the country enacted an entire menu of extreme tort restrictions, it could go no farther than to find an extremely small percentage of

³³ See, Americans for Insurance Reform, *True Risk: Medical Liability, Malpractice Insurance And Health Care* (July 2009), <http://insurance-reform.org/pr/090722.html>.

³⁴ The Medicare law states: “It shall be the obligation of any health care practitioner and any other person...who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act...will be provided economically and only when, and to the extent, medically necessary.” 42 U.S.C. § 1320c-5(a)(1). Also, “[N]o payment may be made under part A or part B for any expenses incurred for items or services...which...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” 42 U.S.C. § 1395y(a)(1)(A). The Medicare claim form (Form 1500) requires providers to expressly certify that “the services shown on the form were medically indicated and necessary for the health of the patient.”

health care savings, about 0.5%, including a 0.3 % savings from slightly less utilization of health care services” or “defensive medicine.”³⁵

Let’s further assume for a minute that the CBO statistics are wrong, that “defensive medicine” is a significant problem driving up the cost of health care – or, as Professor Fred Hyde, M.D., Clinical Professor in the Department of Health Policy and Management at Columbia University’s Mailman School of Public Health, defined it:

That, in contravention of good medical judgment, the basic rules of Medicare (payment only for services that are medically necessary), threats of the potential for False Claim Act (prescribing, referring, where medically unnecessary), physicians will, as a group, act in ways which are possibly contrary to the interests of their patients, certainly contrary to reimbursement and related rules, under a theory that excessive or unnecessary prescribing and referring will insulate them from medical liability.³⁶

Even assuming “defensive medicine” exists, we know that stripping away patients’ rights does absolutely nothing to stop doctors from complaining about “defensive medicine,” and enacting this proposal will not either. In fact, no researcher has ever found that limiting litigation has any impact whatsoever on the ordering of tests. Texas is a good example.

In June 2009, Dr. Atul Gawande published an article in the *New Yorker* magazine called “The Cost Conundrum; What a Texas town can teach us about health care,” which explored why the town of McAllen, Texas “was the country’s most expensive place for health care.”³⁷ The following exchange took place with a group of doctors and Dr. Gawande:

“It’s malpractice,” a family physician who had practiced here for thirty-three years said.

“McAllen is legal hell,” the cardiologist agreed. Doctors order unnecessary tests just to protect themselves, he said. Everyone thought the lawyers here were worse than elsewhere.

That explanation puzzled me. Several years ago, Texas passed a tough malpractice law that capped pain-and-suffering awards at two hundred and fifty thousand dollars. Didn’t lawsuits go down?

“Practically to zero,” the cardiologist admitted.

³⁵ Congressional Budget Office, “CBO’s Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice (‘Tort Reform’),” October 9, 2009, <http://www.cbo.gov/publication/41334>.

³⁶ Fred Hyde, M.D., Clinical Professor, Department of Health Policy and Management, Columbia University Mailman School of Public Health, “Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussions; Is There a Role for ACOs, CER, PCORI and ‘Health Reform’ in ‘Tort Reform.’” (2010). Dr. Hyde holds both medical and law degrees from Yale and an MBA from Columbia, consults for hospitals, physicians, medical schools and others “interested in the health of hospitals,” has served twice as chief executive of a non-profit hospital and as vice president of a major university teaching hospital. The article was funded by a grant from CJ&D and has been submitted for publication.

³⁷ Atul Gawande, “The Cost Conundrum,” *New Yorker*, June 1, 2009, http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande.

“Come on,” the general surgeon finally said. “We all know these arguments are bulls#*t. There is overutilization here, pure and simple.” Doctors, he said, were racking up charges with extra tests, services, and procedures.

In June 2012, the *Journal of Empirical Legal Studies* published a groundbreaking study, which concluded that limiting injured patients’ legal rights does nothing to reduce overall health-care spending.³⁸ Professor Bernard S. Black, Northwestern University – School of Law, Northwestern University – Kellogg School of Management and the European Corporate Governance Institute (ECGI); David A. Hyman, University of Illinois College of Law; Myungho Paik, Northwestern University School of Law; and Charles Silver, University of Texas School of Law examined Medicare spending after Texas enacted severe “tort reform” in medical malpractice cases and found no evidence of a decline in health-care utilization or impact on so-called “defensive medicine.” Among the report’s key findings:

- “A major exogenous shock to med mal risk from the reforms had no material impact on Medicare spending (in effect, health-care quantity), no matter how we slice the data.”³⁹ Also “[w]e find no evidence that overall health-care spending, physician spending, or imaging and lab spending declined more in counties with higher med mal risk.... If anything, we find some evidence, well short of definitive, that physician spending rose after reform in larger, high-risk counties.”⁴⁰
- There are many reasons why “tort reform” doesn’t lower health-care spending. Said the authors, “One possibility is that there may not be much ‘pure’ defensive medicine – medical treatments driven solely by liability risk. If liability is only one of a number of factors that influence clinical decisions, even a large reduction in med mal risk might have little impact on health-care spending.”⁴¹ In fact, “[l]ower med mal risk could lead some doctors to practice less defensive medicine, yet make other doctors more willing to offer aggressive medical treatment that is profitable to the doctor but of doubtful value to the patient.”⁴²
- Moreover, “[p]olitically convenient myths are hard to kill. The myth that defensive medicine is an important driver of health-care costs is convenient to politicians who claim to want to control costs, but are unwilling to take the unpopular ... steps needed to do so. It is convenient for health-care providers, who prefer lower liability risk. It is also convenient for members of the public, who find it easy to blame lawyers and the legal system for problems that have more complex and difficult roots, and call for stronger responses.”⁴³

³⁸ Myungho Paik et al., “Will Tort Reform Bend the Cost Curve? Evidence from Texas,” *Journal of Empirical Legal Studies* (June 2012), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1635882.

³⁹ *Id.* at 209.

⁴⁰ *Ibid.*

⁴¹ *Id.* at 210.

⁴² *Ibid.*

⁴³ *Id.* at 210-11.

In his 2010 article, “Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussions,” Columbia University Mailman School of Public Health Clinical Professor Dr. Fred Hyde found that “[t]he cost, if any, of defensive medicine, are trivial, in comparison to the cost of health care.”⁴⁴

Hyde also noted the other major problem with the “defensive medicine” argument: the almost exclusive reliance on anonymous physician “surveys” to establish its widespread existence, on which many analysts have “cast doubt as an objectively verifiable means of establishing the presence, quantity or scope of defensive medicine.” The proponents of the Georgia proposal are using these unverifiable physician surveys to claim that a large percentage of Georgia physicians engage in defensive medicine and that it is costing the state billions of healthcare dollars annually. Policymakers should not be fooled by the use of such dubious methods. Such surveys are usually conceived by organized medicine, whose purpose is to give the impression of a scientifically conducted poll, yet they are not. In fact, in 2003, the General Accountability Office (GAO) condemned the use of “defensive medicine” physician surveys, noting everything from low response rates (10 and 15 percent) to the general failure of surveys to indicate whether physicians engaged in “defensive behaviors on a daily basis or only rarely, or whether they practice them with every patient or only with certain types of patients.”⁴⁵ GAO also noted that those who produced and cited such surveys “could not provide additional data demonstrating the extent and costs associated with defensive medicine.”⁴⁶ And, “[s]ome officials pointed out that factors besides defensive medicine concerns also explain differing utilization rates of diagnostic and other procedures. For example, a Montana hospital association official said that revenue-enhancing motives can encourage the utilization of certain types of diagnostic tests, while officials from Minnesota and California medical associations identified managed care as a factor that can mitigate defensive practices.”⁴⁷ Moreover, “[a]ccording to some research, managed care provides a financial incentive not to offer treatments that are unlikely to have medical benefit.”⁴⁸

The fact is that under our health care system, physicians are paid by the services they provide (*i.e.*, the “overutilization” problem referred to by the Texas cardiologist, referenced above) and not by outcome. A recent *60 Minutes* investigation on end-of-life care found, for example, that “there are other incentives that affect the cost and the care patients receive. Among them: the fact that most doctors get paid based on the number of patients that they see, and most hospitals get paid for the patients they admit... ‘So, the more M.R.I. machines you have, the more people are gonna get M.R.I. tests?’ [Steve] Kroft asked. ‘Absolutely,’ [Dr. Elliott Fisher, a researcher at

⁴⁴ Fred Hyde, M.D., Clinical Professor, Department of Health Policy and Management, Columbia University Mailman School of Public Health, “Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussions; Is There a Role for ACOs, CER, PCORI and ‘Health Reform’ in ‘Tort Reform.’” (2010).

⁴⁵ General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836 (August 2003) at 27, <http://www.gao.gov/new.items/d03836.pdf>.

⁴⁶ *Ibid.*

⁴⁷ *Ibid.*

⁴⁸ *Ibid.*

the Dartmouth Institute for Health Policy] said.”⁴⁹ An August 7, 2012 *New York Times* investigation of HCA hospitals found something similar, specifically:⁵⁰

- “[U]nnecessary – even dangerous – procedures were taking place at some HCA hospitals, driving up costs and increasing profits.”
- “HCA, the largest for-profit hospital chain in the United States with 163 facilities, had uncovered evidence as far back as 2002 and as recently as late 2010 showing that some cardiologists at several of its hospitals in Florida were unable to justify many of the procedures they were performing. ... In some cases, the doctors made misleading statements in medical records that made it appear the procedures were necessary, according to internal reports.”
- “[T]he documents suggest that the problems at HCA went beyond a rogue doctor or two.... Cardiology is a lucrative business for HCA, and the profits from testing and performing heart surgeries played a critical role in the company’s bottom line in recent years.”

Finally, there is another reason to cast doubt on the widespread existence of “defensive medicine.” It is against the law. A doctor who bills Medicare or Medicaid for tests and procedures done for a purpose other than what is medically necessary for a patient is committing fraud under federal and state Medicare/Medicaid programs.

- The Medicare law states: “It shall be the obligation of any health care practitioner and any other person...who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act...will be provided economically and only when, and to the extent, medically necessary.”⁵¹ “[N]o payment may be made under part A or part B for any expenses incurred for items or services...which...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”⁵²
- Providers cannot be paid and/or participate in the Medicare program unless they comply with these provisions, and they impliedly certify compliance with these provisions when they file claims. Thus, if they are not in compliance, the certifications and the claims are false. Providers who do not comply and/or file false claims can be excluded from the Medicare program.⁵³

⁴⁹ “The Cost of Dying: End-of-Life Care,” *60 Minutes*, August 6, 2010, http://www.cbsnews.com/2102-18560_162-6747002.html?tag=contentMain:contentBody.

⁵⁰ Reed Abelson and Julie Creswell, “Hospital Chain Inquiry Cited Unnecessary Cardiac Work,” *New York Times*, August 7, 2012, <http://www.nytimes.com/2012/08/07/business/hospital-chain-internal-reports-found-dubious-cardiac-work.html>.

⁵¹ 42 U.S.C. § 1320c-5(a)(1).

⁵² 42 U.S.C. § 1395y(a)(1)(A).

⁵³ See, e.g., *Mikes v. Strauss*, 274 F. 3d 687, 700-1 (2d Cir. 2001) and cases cited therein (holding that compliance with § 1320c-5(a)(1) is a condition of participation in the Medicare program but not a condition of payment; other

Perhaps more importantly, the Medicare claim form (Form 1500) requires providers to expressly certify that “the services shown on the form were medically indicated and necessary for the health of the patient.”⁵⁴ If the services are not, to the doctor’s knowledge, medically necessary, the claim is false. No matter what doctors may say in vague lobbying-generated “surveys,” when it comes to actual tests and procedures, we doubt that most doctors are engaged in the routine fraudulent billing of Medicare, or of Medicaid or private health insurers, for that matter.

Physician Supply

One of the claims made by the proponents of the Georgia proposal is that their new malpractice system is needed to enable Georgia to keep physicians practicing there and to recruit new physicians to the state. There are years of studies showing no correlation between where physicians decide to practice and liability laws. The most recent is an examination of Texas physician supply by Professor Bernard S. Black, Northwestern University – School of Law, Northwestern University – Kellogg School of Management and the European Corporate Governance Institute (ECGI); David A. Hyman, University of Illinois College of Law; Myungho Paik, Northwestern University School of Law; and Charles Silver, University of Texas School of Law.⁵⁵ The methodology of this study, which controls for every conceivable factor, is so accurate that a national “tort reform” proponent admitted changing his mind about the issue after examining the work.⁵⁶ The authors found:

- “[T]he assertion by tort reform proponents that Texas experienced an ‘amazing turnaround’ after suffering an ‘exodus of doctors from 2001 through 2003’ is doubly false. There was neither an exodus before reform nor a dramatic increase after reform.”⁵⁷
- “[T]he rate of increase in Texas DPC physicians per capita was lower after reform.”⁵⁸
- “[T]ort reform did not solve Texas’ physician supply issues.”⁵⁹
- “Physician supply appears to be primarily driven by factors other than liability risk, including population trends, location of the physician’s residency, job opportunities

courts do not make that distinction, *e.g.*, *United States ex rel. Kneepkins v. Gambro Healthcare, Inc.*, 115 F. Supp. 2d 35, 41 (D. Mass. 2000) (holding that compliance with § 1320c-5(a)(1) is a condition of payment).

⁵⁴ See, <http://www.cms.gov/cmsforms/downloads/CMS1500805.pdf>.

⁵⁵ David A. Hyman et al., “Does Tort Reform Affect Physician Supply? Evidence from Texas” Northwestern Law & Econ Research Paper 12-11; Illinois Program in Law, Behavior and Social Science Paper No. LBSS12-12; U of Texas Law, Law and Econ Research Paper No. 225, June 14, 2012, <http://ssrn.com/abstract=2047433>.

⁵⁶ See, Manhattan Institute’s Ted Frank, “Post-tort-reform Texas doctor supply,” *PointofLaw.com*, May 4, 2012, <http://www.pointoflaw.com/archives/2012/05/post-tort-reform-texas-doctor-supply.php> (“I, for one, am going to stop claiming that Texas tort reform increased doctor supply without better data demonstrating that.”)

⁵⁷ David A. Hyman et al., “Does Tort Reform Affect Physician Supply? Evidence from Texas” Northwestern Law & Econ Research Paper 12-11; Illinois Program in Law, Behavior and Social Science Paper No. LBSS12-12; U of Texas Law, Law and Econ Research Paper No. 225, June 14, 2012, at 14, <http://ssrn.com/abstract=2047433>.

⁵⁸ *Id.* at 3.

⁵⁹ *Id.* at 19.

within the physician's specialty, lifestyle choices, and demand for medical services, including the extent to which the population is insured."⁶⁰

As Cornell Law Professor Ted Eisenberg also found in his April 2012 article:⁶¹

If increasing premiums drive exit decisions, then programs alleviating premiums should have effects. But Smits et al. (2009) surveyed all obstetrical care providers in Oregon in 2002 and 2006. Cost of malpractice premiums was the most frequently cited reason for stopping maternity care. An Oregon subsidy program for rural physicians pays 80 percent of the professional liability premium for an ob/gyn and 60 percent of the premium for a family or general practitioner. Receiving a malpractice subsidy was not associated with continuing maternity services by rural physicians. Subsidized physicians were as likely as nonsubsidized physicians to report plans to stop providing maternity care services. And physician concerns in Oregon should be interpreted in light of the NCSC finding, described above, that this was a period of substantial decline of Oregon medical malpractice lawsuit filings.

In August 2003, the U.S. General Accountability Office (GAO) released a study⁶² ostensibly to find support for the AMA's assertions that a widespread health care access "crisis" existed in this country caused by doctors' medical malpractice insurance problems. GAO found that the AMA and doctor groups had based their claims on information GAO determined to be "inaccurate"⁶³ and "not substantiated,"⁶⁴ and that to the extent there are a few access problems, many other explanations can be established "unrelated to malpractice,"⁶⁵ that problems "did not widely affect access to health care"⁶⁶ and/or "involved relatively few physicians."⁶⁷ The health care access problems that GAO could confirm were isolated and the result of numerous factors having nothing at all to do with the legal system. Specifically, GAO found that these pockets of problems "were limited to scattered, often rural, locations and in most cases providers identified long-standing factors in addition to malpractice pressures that affected the availability of services."⁶⁸

Other studies have also rejected the notion that there has been any legitimate access problem due to doctors' malpractice insurance problems. In August 2004, the National Bureau of Economic Research researchers found: "The fact that we see very little evidence of widespread physician exodus or dramatic increases in the use of defensive medicine in response to increases in state malpractice premiums places the more dire predictions of malpractice alarmists in doubt. The

⁶⁰ *Id.* at 25.

⁶¹ Theodore Eisenberg, "The Empirical Effects of Tort Reform," *Research Handbook on the Economics of Torts*, (forthcoming), April 1, 2012, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2032740.

⁶² General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836 (August 2003), <http://www.gao.gov/new.items/d03836.pdf>.

⁶³ *Id.* at 17-18.

⁶⁴ *Id.* at 5, 16.

⁶⁵ *Id.* at 16-17

⁶⁶ *Id.* at 5, 12, 16

⁶⁷ *Id.* at 5, 17.

⁶⁸ *Id.* at 13.

arguments that state tort reforms will avert local physician shortages or lead to greater efficiencies in care are not supported by our findings.”⁶⁹

Other state-specific studies draw the same conclusion. In April 2007, Michelle Mello of the Harvard School of Public Health and her colleagues published a study of physician supply in Pennsylvania in the peer-reviewed journal, *Health Affairs*. The authors “looked at the behavior of physicians in ‘high-risk’ specialties – practice areas such as obstetrics/gynecology and cardiology for which malpractice premiums tend to be relatively high – over the years from 1993 through 2002. They found that contrary to predictions based on the findings of earlier physician surveys, only a small percentage of these high-risk specialists reduced their scope of practice (for example, by eliminating high-risk procedures) in the crisis period, 1999-2002, when malpractice insurance premiums rose sharply.... What’s more, the proportion of high-risk specialists who restricted their practices during the crisis period was not statistically different from the proportion who did so during 1993-1998, before premiums spiked. ‘It doesn’t appear that the restrictions we did observe after 1999 were a reaction to the change in the malpractice environment,’ said Mello, the C. Boyden Gray Professor of Health Policy and Law at the Harvard School of Public Health.”⁷⁰

Similarly, the *Cincinnati Enquirer* reviewed public records in Ohio in the midst of that state’s medical malpractice insurance crisis. The investigation found “more doctors in the state today than there were three years ago ... ‘[T]he data just doesn’t translate into doctors leaving the state,’ says Larry Savage, president and chief executive of Humana Health Plan of Ohio.”⁷¹

Past studies have also shown there to be no correlation between where physicians decide to practice and state liability laws. One study found that, “despite anecdotal reports that favorable state tort environments with strict ... tort and insurance reforms attract and retain physicians, no evidence suggests that states with strong ... reforms have done so.”⁷² A 1995 study of the impact of Indiana’s medical malpractice “tort reforms,” which were enacted with the promise that the number of physicians would increase, found that “data indicate that Indiana’s population continues to have considerably lower per capita access to physicians than the national average.”⁷³

⁶⁹ Katherine Baicker and Amitabh Chandra, “The Effect of Malpractice Liability on the Delivery of Health Care,” *NBER Working Paper Series* (August 2004) at 24, <http://www.dartmouth.edu/~kbaicker/BaickerChandraMedMal.pdf>.

⁷⁰ “Malpractice Premium Spike In Pennsylvania Did Not Decrease Physician Supply,” *Health Affairs*, April 24, 2007, <http://www.healthaffairs.org/press/marapr0707.htm>.

⁷¹ Tim Bonfield, “Region Gains Doctors Despite Malpractice Bills,” *Cincinnati Enquirer*, October 10, 2004, http://www.enquirer.com/editions/2004/10/10/loc_doctor.day1.html.

⁷² Eleanor D. Kinney, “Malpractice Reform in the 1990s, Past Disappointment, Future Success?” 20 *J. Health Pol. Pol’y & L.* 99, 120 (1996), cited in Marc Galanter, “Real World Torts: An Antidote to Anecdote,” 55 *Maryland L. Rev.* 1093, 1152 (1996), <http://marcgalanter.net/documents/realworldtortsananditotoanecdote.pdf>.

⁷³ Eleanor D. Kinney and William P. Gronfein, “Indiana’s Malpractice System: No-Fault by Accident,” 54 *Law & Contemp. Probs.* 169, 188 (1991), cited in Marc Galanter, “Real World Torts: An Antidote to Anecdote,” 55 *Maryland L. Rev.* 1093, 1152-1153 (1996), <http://marcgalanter.net/documents/realworldtortsananditotoanecdote.pdf>.

CONCLUSION

Over the years, states and Congress have occasionally considered proposals that require or pressure wrongly injured persons to have their disputes resolved outside the court system and/or force them to obtain compensation from a newly-created state governmental agency. It would be one thing if any of these systems succeeded and could be considered appropriate models. But none has. This is due not to poor legislative construction or elements that can be fixed. Rather, it is because of one inherent flaw that infects all such systems; namely, once an area of law is removed from the civil justice system and is taken over by a government bureaucracy, it becomes a rigid, dictatorial system that is immediately and forever vulnerable to manipulation by political forces, turning it into a nightmare for those it was originally meant to help.

Forcing Georgia patients into such a system would violate the constitutional rights of Georgia citizens and strip juries of their quintessential fact-finding function, which was unequivocally reaffirmed by the Georgia Supreme Court just two years ago. This “improvement” would be purchased at the cost of blunting the free market deterrent effect that the tort system now provides. Proponents of this proposal are misguided and their proposal should be rejected as bad public policy for Georgia.