

TESTIMONY OF
ROBERT C. BAKER
PRESIDENT, AMERICAN BOARD OF TRIAL ADVOCATES

PRESENTED BY
KARL KEENER
MEMBER, AMERICAN BOARD OF TRIAL ADVOCATES

BEFORE THE
SUBCOMMITTEE ON ECONOMIC AND COMMERCIAL LAW
COMMITTEE ON THE JUDICIARY
U.S. HOUSE OF REPRESENTATIVE
JUNE 22, 1994

I am Robert C. Baker, National President of the American Board of Trial Advocates. I am a Senior Partner in the firm of Baker, Silberberg & Keener, located in Santa Monica, California.

The American Board of Trial Advocates (ABOTA) is an organization of over 4000 distinguished litigators from all 50 states. We are unique in that our membership is almost evenly divided between lawyers representing plaintiffs and lawyers representing defendants. The composition of ABOTA's membership insures that its position on such issues as medical malpractice reform is balanced. ABOTA members have a distinctive understanding of the civil justice system, since a lawyer must have tried 20 civil jury trials to verdict, in order to be even considered for membership in our organization.

The majority of my personal practice for the last twenty plus years has been devoted to defending physicians at the request of their medical malpractice insurance carrier. Indeed, my firm generates most of its income through the defense of physicians at the request of medical malpractice insurers.

Today, I would like to give you my opinion,^{cc} as a lawyer who represents the health industry not the plaintiff, on how medical malpractice reform has affected malpractice litigation in California. This should be important to this Committee's consideration since many proponents of malpractice reform cite the California law as successful reform and have incorporated many of its provisions in proposed federal legislation.

As you may recall the "MICRA" limitations were passed by the California Legislature in 1975 and were held constitutional by the California Supreme Court in almost all particulars in 1984 and 1985. We have had, therefore, approximately 10 years of experience with alleged malpractice reforms.

In my view, those malpractice reforms have aided insurance companies and physicians, but have, to a significant extent, been detrimental to persons injured by medical negligence.¹¹ As a result of caps on damages, as well as limitations on attorneys' fees, most of the exceedingly competent plaintiff's lawyers in California simply will not handle a medical malpractice case.⁷⁾ This is a fact, and let me explain why.

First, the contingent fee allows access to the courts for those who lack the means to pay a lawyer's hourly fees. It provides a client the means to finance litigation with funds essentially borrowed from the lawyer. If the lawyer loses the case it is as if he or she made a bad loan.

Lawyers cannot earn a living by making bad loans, so they will only make those loans when there is a good opportunity for a return. The sliding scale limitation on the contingent fee further reduces those opportunities, since it has the effect of underestimating the amount of time needed for particular cases.

Medical malpractice cases can take years to resolve and thousands of hours of attorney time. They are notoriously risky. I would also suggest that even if some attorneys would still take these cases, the quality of counsel would not be the same.

Moreover, when the contingent fee limitation is restricted to one area of tort law, such as medical malpractice, tort lawyers simply shift into more profitable areas of practice. This only worsens the problem of the inability of medical malpractice victims to obtain representation.

The result is that those attorneys that choose to handle medical malpractice cases concentrate on only those cases that have high economic damages associated with them, such as cases commonly referred to as "bad baby cases," wrongful death cases of a breadwinner, or cases involving demonstrable brain damage. Those cases also attract the attention of the media and the public and lead to the misunderstanding that surrounds medical malpractice litigation.

((There are entire categories of cases that have been eliminated since malpractice reform was implemented in California. The victims of cases that have a value between \$50,000 and \$150,000 are basically without representation.)) As an example, incidents of failure to diagnose an appendicitis still occur, but suits are not filed to any extent in California. The reasons for this are simple:

(1) 80% of medical malpractice cases that go to trial are won by the defendant medical practitioner;

(2) Medical malpractice cases by their very nature are expensive.

(3) Physicians in California, as in virtually all states have the ability to withhold consent to settle and, therefore, the physicians control whether a case is settled or goes to trial;

(4) Physicians in California are required to report malpractice settlements to the Medical Board of California.

If, by settling, a physician is to be reported to the Medical Board, he or she has very little to lose by proceeding to a trial where the chances of success are 80%. They are in no worse position professionally if they lose than they would be by being reported to the Medical Board. Under those conditions, given the expense to the plaintiff and the plaintiff's attorney, cases in the \$50,000-\$150,000 range are rarely filed.

On the other hand, of the medical malpractice cases filed, a far greater number will proceed to trial, as opposed to being settled. In California a significantly higher percentage of medical malpractice cases go to trial--the costly alternative--than any other type of case.

Medical malpractice premiums have not diminished in California as a result of MICRA, nor to my knowledge have they in any state that has enacted alleged medical malpractice reform. There can be little doubt that with caps on pain and suffering and limitations on attorneys' fees there are fewer cases being filed (although, as stated, of those filed more go to trial). I believe these realities confirm the studies conducted elsewhere, which assert that damages recovered from litigation are not unwarranted nor are they a prime cause for high malpractice premiums.

A Harvard study¹ in 1990 found that of more than 27,000 victims of doctor negligence, fewer than one in eight filed suit, and less than 40% of those victims, or 5% of the total, recovered compensation. A more comprehensive study² by Professor Neal Vidmar at Duke University School of Law broadly examined malpractice litigation in North Carolina and found of the nearly 900 cases that were filed in a three-year period in North Carolina, 40% were terminated without payment to plaintiff, 50% resulted in a settlement, and 10% were eventually decided by a jury.

The plaintiffs in jury cases prevailed in one out of five times, which is approximately the national average. There were only four large awards out of the 117 cases that went to trial and the median award of those 117 lawsuits was \$36,500.00

¹Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, a report by the Harvard Medical Practice Study to the State of New York (1990).

²Neil Vidmar, "The Unfair Criticism of Medical Malpractice Juries," Judicature, October-November 1992, Vol. 76, No. 3.

In H.R. 3600 there are provisions for an alternative dispute resolution process through which consumers are required to first attempt to resolve the claim. In addition, there is the reporting requirement that allows the public to obtain access to information contained in the National Practitioner Data Bank.

Similar to the situation in California in which the physician has little incentive to settle, these two provisions work at cross-purposes. First, mandatory ADR is very expensive and will cost the plaintiffs and the plaintiff's attorneys, as well as the defendants and their insurers, considerable monies with which to comply. However, the chances of success of ADR are exceedingly diminished by the reporting requirements to the National Practitioner Data Bank.

In other words, if a physician wins the ADR, and the patient opts to go no further, then obviously the dispute between the patient and the physician would end. In the alternative, if the patient wins the ADR, the physician has little to lose by seeking the jury trial to which he or she is entitled. Unless some sort of reporting floor is established, the alternative dispute resolution process, in my opinion, will not eliminate a significant number of disputes.

If the Congress is intent on enacting malpractice reforms which include the mandatory reporting to a National Practitioner Data Bank, then this committee should consider incorporating a provision requiring only those health care providers that settle, or incur verdicts and/or judgements in excess of \$50,000 to report the matters to the National Practitioner Data Bank. This, in my view, would result in far more physicians consenting to settlements of the more minor cases, thereby removing a large number of lawsuits from our already clogged judicial system.

It is my opinion that malpractice reform has not worked in California for the injured victims of medical negligence. Physician groups report that there has been no reduction in their medical malpractice premiums. As the number of case filings has diminished and dollar amounts of awards have decreased, one can assume medical malpractice reform is benefitting some entity, but it most certainly is not benefitting the average citizen in our country.)

With health care costs in the United States running at \$800 billion annually, and medical malpractice insurance running around \$6 billion--less than 1%, alleged medical malpractice reform is not the answer to reducing health care costs in the United States. In my view, this committee could do more to assist the American public by looking at some of the real costs that are incurred in the delivery of health care in our country.

One would not have to look beyond the most frequently performed surgery in the United States--the implantation of intraocular lens. The fifteen-minute operation may be performed by a physician anywhere from 6 to 20 times a day for which the charge may be \$2,500 or higher per operation. That same procedure in an outpatient hospital setting will cost in excess of \$7,500. The intraocular lens that is implanted by the physician may have approximately three to four cents of plastic in it and cost the hospital \$100-\$200. As of the early 1990's, the United States government was paying more for the implantation of intraocular lenses than for the next four most frequently performed operations combined.

Another example of real costs is the proliferation of expensive CAT and MRI machines. In the City of Santa Monica where I practice there are 7 MRI machines which are more than in the entire country of Canada. Because of their proliferation these wonderful but expensive machines are under-utilized. As a result, the cost of the diagnostic tests have gone up in order to cover the cost of the machine.

To conclude, it is my view, based on a significant amount of experience in the California experiment, that a reduction in health care costs is not going to be achieved by some of the far-reaching medical malpractice reform proposals now being considered by the Congress. What will occur is that victims of medical negligence will have a decreased opportunity for redress.

Thank you.