# Medicaid Redesign Team Medical Malpractice Work Group
## Minutes for Meeting of October 27, 2011

Co-chairs Kenneth Raske and Joseph Belluck welcomed the group.

Each co-chair briefly discussed what particularly struck him about the presentation and questions and answers during the first work group meeting. Mr. Raske was struck by the great variations in premiums within New York State, which outweigh cost of living variations among the regions and the cost of the tort system in terms of the percentage of the awards that pay for the administrative costs of the process (approximately 60%). Mr. Belluck was struck by the persistent lack of data on all of the issues that had been discussed.

The following speakers gave presentations under the general topic of "the Effectiveness of the Tort System in Resolving Medical Malpractice Claims and Promoting Patient Safety, followed by a question/comment and answer period after each presentation.

J. Robert Hunter: Director of Insurance, Consumer Federation of America; Former Federal Insurance Administrator; Former Commissioner of Insurance for the State of Texas. Mr. Hunter stated that reviews of insurance rates from 1967-2009 show periodic cycles of "hard market" with high reserves for a period of 2-3 years, followed by a "soft market" period during which rates go down and the high reserves are "soaked up." With regard to New York State, in particular, Mr. Hunter stated that premiums increased at a rate greater than the rate of inflation during the period from 1975-1989 but that since then, rates have dropped (as adjusted for inflation). He questioned whether overestimating for incurred claims has occurred, resulting in reserves in New York being overinflated compared to the rest of the nation.

Speaking about New York's Medical Malpractice Indemnity Pool, Mr. Hunter said that it is difficult to determine if the $470 M present estimate of the deficit is accurate because he doesn't know what data was used in arriving at that estimate. On the issue of the availability of medical malpractice insurance in New York, he concluded from the data he did examine that physicians do not have difficulty obtaining malpractice insurance; and he also found that despite the high cost of malpractice insurance in New York, the state still has a high doctor/population ratio.

Mr. Hunter stated that New York suffers from "an extreme lack of data on medical malpractice;" and provided a list of key missing data needed to do an adequate study of New York State's medical malpractice insurance situation. In conclusion, he suggested that a comparison be done between certain areas in New York areas in which premium rates are high with areas that have similar demographics in contiguous states to see what the rates are in those areas.

**Question/comment and answer period:**

Joel Glass stated that the MMIP is, in fact, bankrupt, that there is a big difference between the availability of coverage for hospitals versus coverage for physicians, that for the most part, there is no commercial insurance available for hospitals downstate (resulting in some hospitals "paying as they go") and that Appellate Division changes to the value of verdicts in the pain and suffering and parental guidance categories have resulted in higher damages being sought in those categories.

Dr. Fougner asked if Mr. Hunter could provide a breakdown by specialty for the data he had provided regarding physician insurance. Mr. Hunter said he could not because the insurance data is not broken down by specialty and that there are limitations in the data analyzed, e.g., an ob/gyn who has stopped doing deliveries is still listed as an ob/gyn.

Edward Amsler asked a series of questions including in what year was slide 2-New York Medical Malpractice History done. (Answer: Spring 2011), whether Mr. Hunter knew that in New York, the Superintendent of Insurance/Financial Services establishes (approves) the rates (Answer: yes) and that most of the information on the slides must have been reviewed by the Superintendent (Answer: Yes but this information is not available to the public and should be).

Fred Hyde asked if there are states that produce sufficiently robust data that people could study. (Answer: Texas and California). Do you believe that when the "good players" (commercial insurers) left, they destroyed the market?

Judge McKeon asked if a rate comparison were to be done with similar demographic areas in contiguous states what did Mr. Hunter think the data would reveal (Answer: He would want to see if the results were similar, including the pricing of rates). Judge McKeon then asked if Mr. Hunter thought it would be worth studying whether payouts are higher in regions with certain demographics.

Michael Cardozo, Corporation Counsel for the City of New York. Mr. Cardozo's office handles HHC medical malpractice appeals as well as the defense of non-HHC medical malpractice cases in which City entities and employees are defendants. His position is that contrary to the goal of the tort system to promptly and efficiently compensate victims of medical malpractice fairly, New York's present tort system is costly to administer (particularly in terms of court costs and legal fees) and inefficient (overly compensates some and punishes hospitals far in excess of the negligence that occurred).

Last year New York City paid $565 M in settlements and verdicts of which $143 M constituted medical malpractice payouts. Over the past 10 years, medical malpractice payouts have dramatically increased. In the 1970's the City paid out 22 times less than what it pays out today.

His recommendations are as follows:

- Cap pain and suffering at $250,000.00 (except for intentional torts) to end the "litigation lottery." This is what 22 other states have done.
- Adopt schedules for quantifying non-economic damages to be presented to juries as "presumptive" amounts; these numbers would not be binding but would provide some guidance to juries.
- Adopt a medical expense threshold. If the plaintiff's medical expenses are less than $5,000.00, there should be no pain and suffering award,
- Eliminate joint and several liability. At present, a defendant who is liable for only 1% can end up paying up to 100% of the economic damages if the other defendant(s) has/have no or insufficient available assets. Thirty other states have eliminated this provision.
- Expand the number of medical malpractice cases adjudicated by judges who are well trained in this area.
- Expand the use of court assisted mediation as early as possible after the filing of a medical malpractice action.
- Encourage judges to hold Frye hearings and to perform their gatekeeping functions.
- Authorize the appointment of independent experts on future costs, standards of care, and causation.
- Apologies to patients should not be admissible in court so that doctors are not deterred from apologizing.
- Eliminate the exception for lawsuits in the statute that protects physicians' statements to quality assurance committees from discovery.
- Require an affidavit of merit for every defendant named in a medical malpractice lawsuit to eliminate physicians who really had no involvement in the events in question from being sued.
- Require every party to identify that party's expert witness within X amount of time following the filing of the Note of Issue and make the parties' experts available for depositions.

Questions/Comments and Answers:

Joseph Belluck asked if the City would agree to limitations on damages when it pursues affirmative litigation. (Answer: Mr. Cardozo has faith in juries but thinks juries need guidance regarding damages.)

Matthew Gaier talked about a case he had involving a man who was blinded as the result of the negligent administration of anesthesia and asked Mr. Cardozo if he thought that losing one's sight is only worth $250,000.00 in pain and suffering ( Mr. Cardozo's answer was essentially that he felt the proposed cap is reasonable). Mr. Gaier asked if his answer would change if there happened to be no economic damages. (Answer: Mr. Cardozo stated that one has to look at the impact of awards collectively.)

John Bonina asked Mr. Cardozo about a case in which the City filed an amicus brief in which the City asserted that if it had to take depositions of treating physicians, it would cost the City $50,000-$200, 000 in costs per case (Answer: Mr. Cardozo said that defendants should at least have the right to do so if they decide it is worth doing.). Mr. Bonina asked if under current law, doesn't the City know who the plaintiff's expert is going to be? (Answer: Mr. Cardozo said the issue is one of timing, i.e., at what point the City learns this information.) Mr. Bonina's final comments/question focused on the impact that certain patient safety measures could have on reducing readmissions and adverse events. (Answer: Mr. Cardozo has no statistics but even with the implementation of more patient safety measures, there will always be some negligence, which is why changes in New York's tort laws are needed.)

Nicholas Papain asked whether it is true that there are some articulated damages standards both by the courts and in statutes. (Answer: Mr. Cardozo has not seen such standards in the Appellate Division changes to verdicts that he has reviewed) Mr. Papain asked if this was Mr. Cardozo's subjective opinion. (Answer: Mr. Cardozo believes that the area in general is subjective and that judges are operating in accordance with what the law is but that the law should be changed to remove some discretion.) The final questions asked by Mr. Papain focused on the fact that the City Comptroller's Report showed there has been both a substantial decrease in the number of medical malpractice claims brought against the City and a significant drop in medical malpractice payouts against the City as a result of an HHC comprehensive risk management initiative. (Answer: Mr. Cardozo agreed but stated that there is still a need for tort reform.)

Nicholas Papain (and Mary Walling), Partner, Sullivan, Papain, Block, McGrath & Cannavo: "The Patient Safety Role of the Tort System."

A study of North Carolina closed claims from 2002-2007 showed that although North Carolina has an active patient safety program, harm as a result of medical care was still very common. What was missing was the implementation of patient safety programs in a reliable, verifiable manner.

Regarding New York State, the HHS Agency for Healthcare Research and Quality 2010 Performance Meter for Hospital Care Measures shows New York in the weak category (categories: very weak, average, strong, and very strong). In ranking, New York ranked 36th (bottom 30%).

Healthgrades lists New York in the bottom 10 states for 2010 (for Medicare patients (surgery and post-surgery).

**Programs that work:**

1. Anesthesiology-A study by the Institute of Medicine found that safety practices instituted by anesthesiologists beginning in1985 had reduced the number of deaths due to anesthesiology 40 fold, malpractice payments involving anesthesiologist are down, and malpractice premiums for anesthesiologists are among the lowest for any specialty.

2. Michigan Keystone ICU Patient Safety Program-The implementation of this program led to a 66% reduction in catheter-related bloodstream infection rates

3. Hospital Corporation of America-A comprehensive redesign of patient safety procedures in OB resulted in a nearly 5 fold reduction in the cost of claims.

4. RAND Corporation. The results of a study released in 2010 demonstrated a link between improving performance on 20 well established indicators of medical safety outcomes and lower medical malpractice claims.

5. NY Presbyterian 2011 Study-A study of a comprehensive obstetric patient safety program beginning in 2002 showed a dramatic drop in compensation payments and sentinel events over period from 2003-2009.

Mr. Papain spent the remainder of his presentation discussing CRICO's emphasis on improving patient safety by means of making "data driven" changes. To do this, CRICO reviews closed claims to analyze what went right, what went wrong, and what can be done differently.

CRICO uses positive incentives in the form of premium reductions to accelerate the adoption of patient safety training and risk management programs. CRICO has found that most mistakes occur as a result of systems problems that create a "window of risk," that patient safety initiatives should be designed to make it hard for a person to make a mistake (e.g., color coded medication tops), and that lack of openness about mistakes made perpetuates risk exposure.

Hon. Anne Pfau, Coordinating Judge of the New York State Medical Malpractice Program, former Chief Administrative Judge for New York State:

Judge Pfau discussed the role of the courts in addressing the medical malpractice problem and how the system must be modified to recognize that not every case needs to be the subject of full blown litigation. The modifications that she believes would be helpful would be the increased use of knowledgeable, proactive judges who can resolve many cases by means of negotiated settlements. The tougher cases would still go to trial. She favors the "Judge McKeon Model" going statewide with judges taking into account the particular demographics and healthcare needs in their regions. Those cases that do go to trial can be used as "lessons learned" to train doctors and hospitals.

**Question/comment and answer period:**

Joseph Belluck stated that an inefficient court system increases the costs of litigation (i.e., extends the time that litigation takes).

Question from someone on the phone: How long does it take to get a doctor who was peripherally or not involved at all in an adverse event removed as a defendant in a lawsuit? Judge McKeon stated that he raised this problem during the first work group meeting and that a doctor should not be sued just because a party doesn't know the extent of a doctor's role in the event.

Hon. Eileen Bransten, NYS Supreme Court, Civil Branch: "Medical Negligence in the NY Court System."

Judge Bransten's position as a judge who tried medical malpractice cases from 2001-2008 is that the present judicial system allows from prompt and fair resolutions and takes care of non-meritorious claims.

Her view is that a potential plaintiff has to find an attorney who is willing to take his or her case and that is difficult to do unless the potential plaintiff has a good case. Once a lawsuit is commenced, the discovery process often results in a settlement. In addition, the defendant(s) can bring a summary judgment motion that requires the plaintiff to bare his/her proof and both sides to submit affidavits from their experts. If the motion is denied, the movant can file an interlocutory appeal.

In her experience, Judge Bransten found that many insurers do not discuss settlement until the brink of trial but that on the whole, there are far more defense verdicts because insurers will settle most difficult cases. She stated that the judges doing medical malpractice cases are very experienced and that there are only 2 full time medical malpractice judges presently because medical malpractice caseloads have decreased.

Once a case has gone to trial the defense can move to set aside the verdict and obtain a de novo review of liability, the fairness of the trial, and the excessiveness of the verdict. If the Appellate Division does reduce the verdict, it usually tells the plaintiff that he or she can take the reduced amount or go to trial again.

**Question/comment and answer period:**

Kenneth Raske asked Judge Bransten to explain why judges are reluctant to hold Frye hearings (Answer: Ninety–nine percent of the time it would give the defense 100% knowledge of what the plaintiff's case will be at trial, which is unfair; she also said that 99% the opinion of plaintiff's expert is not based on junk science).

Joel Glass stated that the subjectiveness of the Appellate Division, particularly with regard to pain and suffering is an issue and that defendants are reluctant to go to verdict because of that (Answer: Judge Bransten's view is that the majority of cases settle and now settle at an earlier point and that the pilot negotiated settlement program should help. She also expressed the view that larger verdicts usually mean larger problems but affirmed her support of earlier settlements.)

Judge McKeon stated that he disagreed with Judge Bransten on the reason that there are large settlements. In his view, large verdicts often occur because there has not been a vigorous effort to settle a case.

Joseph Belluck asked Judge McKeon if he feels that the rules in New York are sufficiently clear regarding the extent to which judges can speak on an ex parte basis to the other side. Judge McKeon stated that he always asks permission and hasn't received any complaints. Mr. Belluck said that upstate judges seem to have a wide range of views on the subject. Judge Pfau stated that there is a wide range of views among judges about what their role should be; some judges feel their role is only to run a good trial, but judges who are participating in the pilot program have a different view. The standards for judges are established by the Judicial Ethics Commission.

Edward Amsler said that MLMIC closes about 70% of its cases with a zero payment; that percentage increases to 90% if the cases go to trial. On the issue of Frye hearings, Mr. Amsler said that New York is the only state in which there are no depositions taken by either side and that the advantages of taking depositions are 1. Depositions may provide a basis for holding a Frye hearing and 2. Depositions may provide a better basis for a decision to settle a case. As a result, these advantages should be weighed against the cost argument for not taking depositions. He said that summary judgment motions have not been very successful and questioned why the certificate of merit proposal regarding every named defendant shouldn't be adopted.

Judge Bransten responded by stating that plaintiff attorneys presently have to certify that the case has merit but admitted that the requirement is not that strong, agreed that most cases should be settled earlier, but continued to defend the present system. Her response to the question regarding why depositions aren't allowed in New York is that in New York, an expert has to state that the defendant(s) deviated from a community standard, that it is difficult for a plaintiff to find a physician to testify that such a deviation has occurred, and that there has been attempts to intimidate experts who have been willing to so testify.

Matt Gaier asked Judge Bransten how common it is at trial that the defense has no idea of what the plaintiff's theory of the case is. (Answer: That is never the case and from the information the defense does have about plaintiff's case, the defense can figure out who the plaintiff's expert will be.)

Judge McKeon responded to Mr. Amsler's question about why multiple defendants are sued by stating that when plaintiffs are asked why they named all of the defendants, the answer is that they aren't sure of various doctors' roles in the event and don't want to have a statute of limitations problem so they sue everyone and sort out who should remain a defendant as the case unfolds. Judge McKeon also said, as he did during the first work group meeting, that most of the cases that proceed to trial are those with a consent policy or requirement.

Dr. Goldman stated that the fact that no depositions are allowed in medical malpractice cases shows that these cases are treated totally differently than all other cases.

Joel Glass said that defendants like depositions because they make it easier to decide whether a case should be settled or must go to trial.

Brian J. Noonan, Vice President, Claims & Litigation Management, New York- Presbyterian Hospital: "The Positives and Negatives of the Tort System for Resolving Medical Malpractice Claims."

Mr. Noonan stated that in his experience at New York-Presbyterian, patient safety is an integral component of the hospital's fabric. The hospital is always looking for new ways to make hospitals safer and partners with other hospitals on patient safety initiatives and the retention of consultants in this area.

He spoke favorably about the early settlement pilot project-more cases are settling and settling at an early stage. Hospitals have to look at the numbers in the aggregate in negotiated settlements; some settle at a higher amount than expected; others settle for less than expected. His hospital reviews a case at an early stage to determine what the extent of the hospital's exposure is. Recently, a plaintiff's attorney sent him a detailed letter prior to filing a lawsuit stating that they would like to resolve the matter without litigation but would sue if they could not. Mr. Noonan supports such an approach, assuming that a detailed outline of plaintiff's case is provided for the defendant to review.

Close to 50% of New York-Presbyterian's cases are disposed of with no payment, but it costs too much money to reach a zero recovery disposition. For example, the hospital spends nearly $2M annually just to defend cases that are willingly dropped by plaintiff attorneys. Mr. Noonan's ideas include (1) requiring a certificate of merit signed by a physician who actively practices within the same specialty as each named defendant; this should not pose a problem for plaintiff attorneys who obtain an early evaluation of a case, (2) obtaining expert depositions (Mr. Noonan understands the cost issue but thinks that factor is overridden by the fact that these depositions help both plaintiffs and defendants determine whether to settle a case.), (3) eliminating the joint and severally liable rule (Why should someone who is only 1% liable have to pay a far higher percentage because that person has more funds?) This rule is also used as leverage by plaintiff attorneys.), and (4) eliminating the exception which permits certain statements [i.e., those of a physician named as a defendant in a lawsuit involving the subject of the proceeding] in a quality assurance proceeding to be discoverable. (The present rule discourages robust peer review discussions.)

Speaking about the Weill-Cornell study, Mr. Noonan said that the article was written by two Cornell obstetricians with no input from the hospital; and although he supports the patient safety measures addressed in the article, there have been sentinel events since the article was published. He is uncomfortable with the article being used to argue that patient safety measures resolve all medical malpractice issues. As an example, although the same initiatives were put into place in two hospitals, the claims experience of both hospitals have been different. One reason for the difference may be the result of different demographics and locale driven factors. In addition, because of the time lag between an event and a lawsuit, it is hard to correlate the relationship between payments and the initiation of patient safety measures quickly. Similarly, given the time lag between the imposition of patient safety factors, the filing of a claim and the resolution of the claim, premiums do not rise or fall immediately but rather, changes occur over a period of years. Mr. Noonan's view is that there is no ONE approach to improvement; rather, a number of varied and incremental steps are required.

**Question/comment and answer period:**

Joseph Belluck: Would you agree with respect to the Medical Indemnity Fund and other 2011 legislative changes that it is too early to know if they have resulted in any savings? (Answer: No, Mr. Noonan has already seen substantial savings with regard to two cases that were assigned to Judge McKeon.) Is there a variety in the quality of lawyers with whom you deal and if so, can you explain the difference? (Answer: Usually the top tier has consulted with an expert and you can see that they have worked up the case for their side; it is actually easier to settle cases with such firms.)

Kenneth Raske asked Joel Glass what his experience has been with these changes.

Joel Glass: We have saved approximately $3-3.5 M a case, which will result in premiums savings for hospitals). Doctors get a 5% premium for taking "best practices" training, and Mr. Glass thinks there will be additional premium savings for doctors over time. Teaching hospitals are way ahead of other hospitals because other hospitals don't have the money to make patient safety improvements. For example, in FOJP hospital, 2 OB's are on duty 24 hours a day, 7 days a week. In addition, hospitals serve different populations. One example is that a hospital that serves a large number of obese patients is going to have more adverse events. How can a hospital change a community's nutrition?

Matthew Gaier: It is too early for the plaintiffs' bar to comment about the MIF because it has not been in operation long enough to see how well enrollees' needs will be met by the Fund. If Mr. Noonan is in favor of pre-action settlements, he should let the plaintiffs' bar know that he is receptive to that approach. With respect to joint and several liability, Mr. Gaier stated that his definition of a peripheral defendant is a defendant who has some culpability although the amount may be small.

Mr. Noonan disagreed about what occurs regarding suing numerous defendants, saying that a decade ago records were handwritten and not as clear to determine which doctors were actually involved in the adverse event; now most records are not handwritten so that it should be much easier to identify who should be named.

Nicholas Papain asked Mr. Noonan to comment on the statement in the article on the Weil-Cornell study that there will be additional savings in the years to come. (Answer: Since that article, a couple of sentinel events have happened; he can't be that optimistic). Mr. Papain then noted that the study was initiated by the hospital's carrier and asked whether the carrier has initiated these practices in other hospitals. (Answer: Yes, all MCIC hospitals have been reviewed, and consultants have recommended "best practices' to follow.)

Judge McKeon: In some instances, patient safety initiatives alone are probably not going to fix the problem. For example, Columbia, Montefiore, and Maimonides are all outstanding teaching hospitals, but one hospital has a higher number of medical malpractice lawsuits than the other two. He believes the demographics of the hospitals may be the explanation.

Joseph Belluck said he would be fully supportive of hospitals being given whatever resources may be available to implement patient safety initiatives. Nicholas Papain agreed that there should be incentives provided for patient safety initiatives to be implemented across the board.

Gregory Serio, Consultant for PRI, former Superintendent of Insurance: spoke about PRI and PRI's approach to medical malpractice. As background, Mr. Serio stated that PRI insures approximately one-third of the market in New York, with a split of 75% physicians and 25% hospitals. PRI's financial situation has improved as a result of a number of management changes and that its next annual statement will show that its reserves will be in the acceptable range.

Since 2002, PRI's claims frequency has been trending downward for both claims made and occurrence based policies and that the severity trend has been stable for the past 10 years and is trending lower. PRI's rate increases have always exceeded its losses. Mr. Serio agreed with Mr. Hunter's chart of March 2011 with regard to written premiums versus paid losses and said that sometimes the industry doesn't ask for increases when they would be small and then complains when requests for major increases are denied.

According to Mr. Serio, actuarial projections are driving the costs of medical malpractice because they look for a high degree of certitude in an industry is which there can't be that degree of certitude. As a result, it takes companies too long to get actuaries to agree that their reserves can be lowered. Rates have been purposefully kept low at times to eat up reserves that are too high.

Risk management is a daily part of PRI's approach to medical malpractice. Mr. Serio stated that patient safety protocols have to be driven aggressively into the market place in order to shorten the learning curve. He thinks that there has been a strategy of not pushing patient safety/risk management for fear that such initiatives will dilute the push for tort reform.

Mr. Serio also stated that there should be more focus on the MMIP because the good doctors are subsidizing the rates of the doctors in the Pool. He thinks this is bad public policy and that the Insurance and Health Committees in the Legislature need to discuss making changes to MMIP rates.

PRI does not think the MIF will result in premium decreases for physicians.

**Question/comment and answer period:**

Joel Glass again noted the difference between coverage for hospitals and coverage for physicians, disagreed with Mr. Serio's comments about actuaries, said that New York is the only state that allows discounting and that actuaries have to take into account insurers' investments. (Answer: Surcharges on carriers for the MMIP should be removed from the law,) Mr. Glass said, however, that those surcharges haven't been imposed.

Edward Amsler said if he was confused by Mr. Serio's comments because if everything has been going so well for PRI, why does it still have a negative surplus? (Answer: Medical malpractice is treated in a unique manner in New York, and a different risk based reserve system should be used.)

Harvey Rosenfield, Founder, "Consumer Watchdog, author of California Proposition 103 (Insurance Regulatory Reform Law): "Analysis of the Impact of California's Insurance Regulatory Law." Mr. Rosenfield got involved in the 1980's when insurance rates were skyrocketing and insurers claimed that an explosive increase of litigation and frivolous claims were the reason for the high rates. There was a lack of data to support the reasons given, however. Proposition 103 mandated a 20% rollback of property and casualty rates; a stringent prior approval process for requested rate increases; and the right of citizens to get the reasons for and the data supporting any rate increase request and to challenge the request, including by filing a lawsuit. Providers themselves never invoked their right to challenge medical malpractice rate increases. In addition, even when claims payments were reduced, premiums went up; and even though caps and other tort "reforms" were put in place in the mid to late 1980's, premiums continued to rise.

After a noticeable rise in 2002-2003 medical malpractice rates, Rosenfield's group began examining rate increase applications and the underlying data. The group concluded and argued that rates should actually be reduced. The issue went to a hearing, and the result was that the 9.9% increase requested was reduced by 70%. Mr. Rosenfield said there was abuse by insurers in inflating their incurred losses. (How much of incurred losses actually become real losses).

Caps are still in effect in California. Mr. Rosenfield says that further tort reforms are not discussed anymore; the emphasis is on patient safety and risk management.

Edward Amsler stated that in New York, the Superintendent of Financial Services establishes the rates for insurance companies owned by physicians. (Answer: Doctors are poor business people and do not do a good job of running businesses, and many companies have made bad merger and speculative acquisition decisions.)

**Question/comment and answer period:**

Robert Hanscom, Senior Vice President, CRICO Strategies (Insurer for the Harvard Medical System), "CRICO's Experience in Using Closed Claims as a Tool in Implementing Patient Safety Initiatives."

Mr. Hanscom stated that the goal of CRICO was to eliminate malpractice by helping providers to provide the safest health care possible. He used the metaphor of an iceberg because malpractice claims are just the tip of the iceberg; what lies beneath includes adverse events and "near misses."

To accomplish its goal of reducing malpractice, CRICO adopted six methodologies: capturing vulnerabilities, integrating data, conducting risk assessments (including the use of focus groups), determining potential solutions, educating and training (viewing the expense of doing so as an investment), and measuring the impact of the education and training. Key areas of risk were identified by examining closed cases. These areas were diagnosis, surgery, treatment, obstetrics, and medication. After patient safety initiative were put into place, ob premiums decreased by 15%. High severity cases trended downward over the period of review, resulting in significant savings.

One example of an area that has been reviewed by CRICO was laparoscopic surgery after a small cluster of claims involving such surgery were filed. What CRICO discovered was that the training conducted was variable. Surgeons were offered a premium incentive to attend another training session. Ten percent of the surgeons who were already performing such surgeries did not pass the re-training. In addition, 20 surgeons declined to take the training because they felt they did not perform many of these surgeries and actually stated that they should not be privileged to perform laparoscopic surgery.

CRICO's emphasis is on "what the data is telling us."

Judge McKeon asked about CRICO's experience with early disclosure and settlement (Answered: CRICO has been supporting early disclosure since 2001-2002. Over the years, the number of cases without merit has declined significantly). Judge McKeon asked what the average payout is in a case in which there has been early disclosure. (Answer: When damages were relatively small, the cases settled for small payouts, but the cases that involved more severe injuries tended to run the normal course.)

Nicholas Papain asked Mr. Hanscom if he still stood by his comment in 2008 that the answer to medical malpractice is not tort reform but rather, the prevention of malpractice. (Answer: Yes he does.)

Everyone was thanked, and the meeting concluded.