

Chapter IV

The Legal System: The Consumer's Best Protection Against Medical Malpractice

The legal system is a difficult, complex and often insurmountable process for those with even the most grievous of injuries. Consumers who have been harmed by medical malpractice face an arduous and by no means certain battle for justice.

However, this is not the image promoted by the medical-insurance establishment. Seeking to discourage lawsuits by victims of malpractice and to deny full compensation for malpractice deaths and injuries, the medical/insurance lobby portrays victims as cheats, judges and juries as dupes, and the judicial system as a bonanza for greedy consumers.

Impressions. Anecdotes. Rhetorical hocus-pocus. Jokes. "Hard numbers" that crumble at a touch. These are among the weapons that insurers, physicians, hospitals and others in the medical lobby employ in their assault on the legal rights of consumers and patients. But the extensive research data available to serious analysts contradict every premise of the medical/insurance establishment's assault on the legal system.

If there were no malpractice, there would be no malpractice lawsuits. Yet the medical industry argues exactly the opposite — as if physicians and hospitals are never negligent or incompetent. It insists that consumers and their attorneys concoct frivolous malpractice lawsuits in order to win massive verdicts. However, even a cursory understanding of how the legal system handles such cases reveals that this contention is false. This chapter explains the facts about the medical malpractice litigation system.

Victims of medical malpractice face difficult obstacles in seeking justice.

A brief review of how the legal system operates explains why, contrary to the propaganda of the medical-insurance complex, so few victims of malpractice seek justice through litigation, and why only a fraction of those obtain it.

First, the malpractice laws recognize that many harms, such as allergic reactions or post-surgical complications, cannot be foreseen or prevented, despite the best quality care: the law does not permit liability in such circumstances.

Indeed, an injury caused by medical treatment does not constitute legal negligence by itself. Under the law, a physician cannot be found liable for malpractice unless he or she failed to exercise what is considered “reasonable care” under the circumstances.⁹⁸ A mistake alone is insufficient. Malpractice is *unusual* carelessness in providing medical care, as judged by standard treatment protocols within a given medical specialty or community. The American legal system allows a jury to decide whether a physician or hospital’s care was so poor that it failed to meet the standard of “reasonable care.”

Second, in court, the burden is upon the patient to prove that the physician’s or hospital’s care was substandard. The patient often cannot obtain all the evidence that might prove he or she received inferior care. Hospital records may not contain the necessary information — or they may have been altered or destroyed. Hospital staff may not remember — or, anxious to protect themselves, they may “forget.” Indeed, the legal community has a term for the manner in which medical professionals refuse to testify against their accused colleagues. It is known as the “conspiracy of silence.”

Further, malpractice victims often must overcome the testimony of “expert witnesses” called by the defendant for the purpose of convincing the jury that the physician’s conduct, however harmful, was “reasonable” under the circumstances. Juries are often impressed by such medical experts, especially since the victims of malpractice frequently find it difficult to hire their own expert physicians to testify in open court that another doctor was negligent.

Finally, even if a physician or hospital obviously committed malpractice, the victim can only receive compensation if she can show that she suffered some form of legal “damages.” These include medical

bills and expenses incurred by the patient as a result of the malpractice and loss of salary or wages because the victim could not work.

Another form of “damage” recognized by the law is commonly called “pain and suffering.”⁹⁹ Unlike payment for the cost of “repairing” the injuries caused by the malpractice, or reimbursing the victim for missing work, “pain and suffering” damages are not based on financial losses. They are awarded to provide monetary compensation for medical mistakes that can never be undone: the woman who, due to a botched appendectomy, has lost the ability to conceive or bear children; the young person who can never pursue a sports career because her doctor failed to set a broken leg properly; the man who went into the hospital to have a cancerous kidney removed, and faced certain death when his doctor removed the *healthy* kidney. In each of these cases, the patient or his or her family would ordinarily be entitled to compensation, not only to cover financial losses, but to cover the anguish and suffering that humans experience in such instances.

The victim of malpractice must prove, first, that a mistake has been made. Second, she or he must prove that the doctor or hospital that made the mistake failed to meet the standard of reasonable medical care in that community — a standard set, of course, by other physicians. Finally, the victim must show that he or she has suffered damage as a result of the mistake. No matter how grievous the injury, the physician or hospital will escape any legal liability for their actions if the victim can show no loss or damage.

Contrary to the complaints of the medical community, the American legal system is stacked in the physician’s or hospital’s favor. The fundamental legal principles which govern personal responsibility and accountability, including the operation of the “contingency fee” system, prevent most malpractice victims from bringing suit. Those who do are usually those with the most significant malpractice injuries. And even they face major hurdles, and are statistically likely to lose.

The contingency fee system discourages all but the most significantly injured victims of malpractice from bringing a lawsuit.

Virtually all trial lawyers who represent victims of medical injury work on a “contingency fee” basis: the attorney is paid for his or her efforts

only if the plaintiff wins or settles the case. The attorney then takes a percentage, which is typically between 25 percent and 40 percent of the funds received.

If the victim loses the case, he or she need not pay the attorney a penny, (except, in some cases, for out of pocket expenses) and the attorney receives no compensation. This is the “contingency” that characterizes the relationship between client and lawyer in most malpractice death or injury cases. As Justice Harry A. Blackmun wrote in a 1987 United States Supreme Court opinion: “The premium added for contingency compensates for the risk of nonpayment if the suit does not succeed.”¹⁰⁰

The “contingency fee” is a uniquely American instrument of justice, well suited to a democracy. Only the wealthy could afford justice if access to the legal system depended upon the ability to pay a lawyer \$100 to \$400 per hour for her or his services.

The contingency fee system encourages lawyers to accept all worthy cases. And it encourages lawyers to seek the maximum possible compensation for the injured victim by offering the attorney a significant percentage of the money obtained for the client.

An important structural advantage of this system is that it precludes frivolous lawsuits. Attorneys operating under a “contingency fee” contract do not knowingly accept a frivolous case when there is no chance of winning such a lawsuit and thus no opportunity to receive compensation for bringing it. As a policy analyst for the Heritage Foundation noted, “rather than encourage baseless lawsuits, the contingency fee actually helps screen them out of the system.”¹⁰¹

This should be compared to the fee arrangements employed by defendants in virtually all civil suits, including malpractice cases. Attorneys for physicians and insurance companies are compensated by the hour, encouraging wasteful and frivolous legal machinations that “run up the meter” and delay justice.

It is little wonder that the “contingency fee” has drawn so much criticism from the insurance industry and the medical profession: it enables low and middle-income consumers to have their day in a court of law.

Understanding how the “contingency fee” system provides effective legal representation to legitimate victims of malpractice is important. The truth undermines the avowed premise behind the doctors’ and insurers’ efforts to restrict the legal rights of victims: that medical malprac-

tice litigation is unjustified and deserves to be “restricted.” In fact, there is *not enough* medical malpractice litigation.

Only a small percentage of malpractice victims file a lawsuit, and even fewer win such suits.

There is no “litigation explosion” of medical malpractice lawsuits. Indeed, just the opposite is the case.

Contrary to the myths purveyed by insurers, very few of the hundreds of thousands of victims of medical negligence or incompetence each year file malpractice suits, and far fewer recover anything. Moreover, the number of malpractice claims filed is stable and slowly shrinking. There is an impressive consensus on this issue among such diverse independent sources as the Harvard School of Public Health, the RAND Corporation, the National Center for State Courts, the UCLA Law Review and the National Association of Attorneys General.

As noted in Chapter I, research by these recognized institutions has revealed the sheer size of the malpractice epidemic. But that is only one of the startling discoveries made by these investigations.

The studies also determined that there were too few, rather than too many, lawsuits for medical malpractice. And of those few victims who do sue, only a small percentage actually obtain compensation.

The comprehensive report by the Harvard School of Public Health, the Harvard Medical Practice Study, found that *only one in eight of victims of medical negligence ever files a lawsuit. And only one in sixteen people ever recovers any damages.*¹⁰² The investigators were surprised to find:

... a far greater gap than we had expected between tortious injuries inflicted on patients in hospitals and tort claims filed against health care providers....we found several times as many seriously disabled patients who received no legal redress for their injury as innocent doctors who bore the burden of defending against unwarranted malpractice claims. Our data make clear, then, that the focus of legislative concern should be that the malpractice system is too inaccessible, rather than too accessible, to the victims of negligent medical treatment.¹⁰³

A recent review of the data from the Harvard study determined that less than one in 33 instances of negligent “adverse events” leads to a malpractice claim.¹⁰⁴

These findings confirm those of many other studies.

- A 1983 study by Patricia Danzon, reviewing data from an earlier study in California, concluded that “at most one in 10 incidents of malpractice result in a claim, and of these, less than half, or one in 25, receive payment.”¹⁰⁵
- Another study, by Michael J. Saks, a social psychologist at the University of Iowa College of Law in Iowa City, Iowa, found that “evidence does suggest that many more meritorious suits could be brought than are brought.”¹⁰⁶
- According to studies of medical malpractice jury trials in North Carolina and Florida, only 20 percent and 14 percent of injured persons who pursued their medical malpractice claims to trial, respectively, obtained favorable verdicts.¹⁰⁷
- A study of claims paid by the largest physician-owned insurance company in New Jersey found that 38 percent of all lawsuits involved care that the *insurance company* considered either “sub-standard” or “unclear.” Payments were made to malpractice victims in only 43 percent of all malpractice lawsuits. “Contrary to many perceptions, our study suggests that physicians usually win cases in which physician care was deemed to meet community standards and that the severity of patient injury has little bearing on whether a physician loses a case.” The study concluded that “unjustified payments are probably uncommon.”¹⁰⁸
- According to Jury Verdict Research, Inc., a private research firm that compiles statistics on civil verdicts, only 31 percent of victims of malpractice who pursued litigation in 1992 obtained a favorable verdict.¹⁰⁹

Collectively, these studies represent a stunning indictment of the medical profession and a complete repudiation of the campaign that it and the insurance industry have generated to further restrict the already narrow rights of malpractice victims.

First, the most recent and most comprehensive study by the Harvard School of Public Health shows that medical malpractice is rampant in U.S. hospitals. However, the study did not investigate malpractice outside of hospitals — in medical clinics, doctors' offices, and long-term care facilities, for example. Nor did it examine deaths and injuries due to defective medical devices or drugs. Thus, the total number of victims of malpractice must be considered far greater than even the chilling estimate reported by this clinical, case-by-case inquiry.

The cost of the epidemic is staggering: Prof. Danzon estimated that the cost of uncompensated injuries to the health care system was \$24 billion in 1984; extrapolating from Danzon's calculation, the Congressional Budget Office put the figure at \$50 billion in 1990.¹¹⁰ In 1993, medical injuries cost \$60 billion, according to Dr. Troyen A. Brennan of the Harvard School of Public Health.¹¹¹

Second, far more malpractice litigation is warranted than actually occurs. The legal system is woefully under-utilized by patients or their next of kin.¹¹² The truth is, medical malpractice is far more common than malpractice lawsuits.

Scientific research also refutes the medical/insurance establishment's assertion that most malpractice lawsuits involve trivial or insignificant injuries. Based on its review of New York State hospital records, the Harvard malpractice study found that the most common instances of negligence and incompetence are: *technical error in an operation, procedure or test* (such as injuries to the intestine or uterus during a hysterectomy, or laceration of a newborn during a cesarean section delivery), 44.4 percent; *misdiagnosis*, 17.1 percent; *failure to prevent illness or injury* (such as ulcers or urinary infections in bedridden patients), 11.6 percent; *wrong drug use or dose*, 10.2 percent; *improper use of tests* (such as the failure to use indicated or up-to-date tests or not acting on test results), 4.8 percent; *treatment delay*, 4.6 percent; *inadequate monitoring or follow-up of treatment*, 4.6 percent; and *other* (such as administering treatment incorrectly, equipment problems, miscommunication between staff, inappropriate or high-risk management, other system failures), 2.5 percent.¹¹³

Jury awards in malpractice cases are remarkably modest.

The perception, rigorously promoted by the insurance industry, that victims of medical malpractice are becoming instant and undeserving millionaires by virtue of litigation, is incorrect.

To begin with, the number of million dollar jury awards has been greatly exaggerated. According to a recent analysis of verdicts (in *all* tort cases, *not* just medical malpractice cases) during 1992, juries awarded more than a million dollars in only 5% of all trials.¹¹⁴ This is not much different from the results of a study in the mid-1980s which found that such awards constituted less than 4 percent of verdicts.¹¹⁵ Between 1990 and 1993, there were a total of 2008 verdicts in the United States in which juries awarded over one million dollars in damages.¹¹⁶ To place this figure in perspective, consider that during this same period, 56.9 million lawsuits were filed in state courts alone.¹¹⁷

Medical malpractice constitutes a small portion of the total litigation in the nation — about 7% of all suits filed in state courts, according to recent data.¹¹⁸ (And only one-third of those who file suit ever receive any compensation, as noted previously.) Between 1990 and 1993, there were only 397 medical malpractice verdicts over \$1 million.¹¹⁹

An average of 132 malpractice verdicts over \$1 million each year can hardly be said to constitute a “legal bonanza” for malpractice victims, when experts have estimated that 150,000 Americans die of medical negligence in hospitals alone each year. Nor is there any basis to suggest that such awards, though large, are unjustified. In fact, a number of economic and medical factors explain how severe malpractice can easily lead a jury to grant compensation of more than one million dollars — and that that might not be enough for serious injuries.

First, inflation has reduced the purchasing power of the dollar by more than two-thirds over the past twenty years. Meanwhile, the cost of medical care, which accounts for most of the money awarded to victims, has skyrocketed even faster than the Consumer Price Index. The costs of hospital care, for example, rose 56 percent more than the CPI from 1975 to 1984. Moreover, as life expectancy continues to grow, the costs of medical care and lost earnings for those who are permanently injured increases commensurately. In addition, advances in medical techniques and equipment have enabled doctors to save malpractice victims who would otherwise have died. These profoundly injured survivors are of-

ten left with handicaps that require expensive, continuous care.¹²⁰ These factors, not delirious juries, nor radical judges, have pushed up the medical bills that malpractice victims must pay.

Indeed, in a review of all lawsuit verdicts over \$1 million between 1962 and 1985, 71 percent of the victims had either died or suffered horrendous injury: paralysis, permanent brain damage, amputations or burns.¹²¹ That a jury would award substantial compensation for such tragic results is quite reasonable, especially if willful or highly negligent behavior is involved.

Nevertheless, the medical/insurance industry persists in citing large malpractice verdicts as proof that juries are handing out “wild” awards and that the legal system is “out of control.”

The focus on million dollar verdicts is misleading in any case. Multi-million dollar awards are a statistical minority; and even the *average* jury award can be greatly exaggerated by a small number of unusually large but merited awards. A much more accurate indication of what the typical injured malpractice victim receives from a jury is the *median*—the award above which are half the remaining awards and below which are the other half.

According to Jury Verdict Research, an independent firm which collects verdict data nationally, the median medical malpractice verdict in 1992 was \$350,000.¹²² Considering inflation and other trends, this figure tracks a study of median verdicts in the early 1980s conducted by the RAND Corporation.¹²³

And even these statistics provide an unreal picture of what a malpractice victim is likely to take home from court, assuming he or she is among the six percent of medical casualties who sue and prevail. The amount of compensation received by medical malpractice victims plummets even lower when settlements are factored into the equation. Many defendants found liable for malpractice will threaten to appeal the decision, an expensive and time-consuming process, unless the victim agrees to accept less than what the jury ordered the defendant to pay. Many verdicts are often reduced by a large percentage through this process. Data on settlements are not available; however, according to a U.S. General Accounting Office study, the median malpractice *payment* was \$18,000 in 1984. Some 69 percent of victims received less than \$50,000.¹²⁴

Malpractice laws save money by discouraging costly negligence.

Though consumers should never be forced to sacrifice the basic human right of physical safety in order to improve the balance sheets of insurance companies and medical providers, extensive research suggests that the industry's self-serving arithmetic is wrong, and a different calculation is in order.

When the medical industry suggests that tort law restrictions would lower health care costs, it is relying on number crunching that includes only the *costs* of liability insurance premiums and claims payouts. It improperly excludes an important financial *benefit* of the malpractice laws: the legal system saves money by deterring costly instances of malpractice.

Professor Patricia Danzon, the expert noted earlier, estimates that the economic costs of physician-caused injuries may be 10 times the total cost of malpractice premiums, or about \$50 billion a year in 1990. Based upon these figures, Professor Danzon concludes that, under a purely economic analysis, the tort liability system would justify its costs even if it deterred only a relatively small proportion — 10 percent — of medical injuries.¹²⁵

Put another way, undermining the restraints placed on malpractice by the legal system would increase, not decrease, health costs.

The Congressional Budget Office came to a similar conclusion in 1992:

The current tort liability system may deter some medical injuries, thereby tending to lower spending on health care. If so, changing the system could raise national health expenditures and other costs associated with medical injury. . . .¹²⁶

An analysis of so-called “defensive medicine” — a linchpin in the AMA's argument for restrictions on malpractice victims' legal rights — actually validates these conclusions.

“Defensive medicine,” according to the AMA, refers to procedures, tests or even surgeries, otherwise unnecessary, but undertaken by practitioners solely to avoid malpractice suits by patients. The medical/insur-

ance lobby contends that the data on premiums, claims and health care costs noted above do not provide a full picture of the impact of malpractice claims on health care costs, and that the cost of “defensive medicine” must be factored in. Recently, the AMA trumpeted a study by a consulting firm, Lewin-VHI, which projected the national cost of “defensive medicine” between 1994 and 1998 to total \$36 billion.¹²⁷ According to the medical/legal establishment, drastic limitations on the legal rights of malpractice victims would “save” insurance companies, doctors and hospitals between \$4 billion and \$9 billion a year by making “defensive medicine” unnecessary.¹²⁸

The urgent issue for the consumer is whether most of what is called “defensive medicine” is truly unnecessary and performed only out of fear of litigation.

After all, “defensive medicine” includes the ordering of additional diagnostic tests; the use of only the safest possible treatments; the habit of keeping patients well-informed about treatment risks; and the process of keeping more complete medical records. If malpractice litigation is promoting this sort of medical practice, then may there be more of it! Except for clearly gratuitous testing, such medical care is exemplary and should help prevent future costly “adverse events.” Or, as a former president of the Federation of State Medical Boards put it in 1984: “It is sad but true that many physicians practice more carefully than they did in the past because they have one eye on the potential litigant.”¹²⁹

To the extent that it can even be defined, therefore, “defensive medicine” is often synonymous with conscientious, high-quality health care. It is clearly not in the best interests of consumers to discourage the practice of what the AMA derisively calls “defensive medicine.”

The Congressional Budget Office concluded:

[I]f the system of medical malpractice liability were modified [to the disadvantage of victims and their attorneys], the resulting change in national health expenditures would be uncertain, and, if any reductions occurred, their magnitude would probably be small. In fact, much of the care that is commonly dubbed “defensive medicine” would probably continue to be provided for reasons other than concerns about malpractice.¹³⁰

In a report to the Congress, the U.S. General Accounting Office made the same point:

Placing greater emphasis on not making mistakes, providers may be performing additional tests and treatment procedures, giving more attention to increased medical recordkeeping, spending more time with patients explaining alternative treatments, obtaining patients' informed consent, and refusing to treat certain high-risk patients. Some of these actions may, in fact, be desirable.¹³¹

The GAO concluded that, "[c]oncerns about the threat of malpractice claims and associated financial losses have been a motivating force in the development of quality assurance activities."¹³²

The Harvard Medical Practice Study Group agreed with other thoughtful analysts that it is:

. . . unclear the extent to which defensive medicine results from the malpractice environment or from other factors such as advances in the science and technology of medicine, changes in societal expectations as to what constitutes an appropriate level of medical care, or changes in [Peer Review Organizations], state, and hospital requirements.¹³³

Indeed, an expert from the Harvard School of Public Health recently announced proof that the malpractice laws discourage malpractice:

[R]ecent empirical analyses demonstrate that at the level of the hospital, as claims *increase* per 1,000 discharges, the risk of negligent injury for patients *decreases*. This is the first statistically significant evidence that there is a deterrent effect associated with malpractice litigation. It suggests that tort litigation, with all of its warts, nonetheless accomplishes the task for which it is primarily intended, that is the prevention of medical injury.¹³⁴

Upon this reasoning, the cost of careful medicine should be taken out of the “defensive medicine” category and moved back into the overall cost of health care.

Truly “unnecessary care” seems to be far less prevalent than is often believed, argues the RAND Corporation in a recent study. Investigators concluded that the number of inappropriate bypass surgeries in its study sample was 2.4 percent, with 7 percent of the surgeries equivocal — instead of the percentages usually cited by the medical and insurance lobbies, 14 percent and 30 percent, respectively.¹³⁵

By the way, the view that “defensive medicine” is synonymous with “high quality care” is a relatively benign view. Many experts have proposed a pecuniary explanation for unnecessary tests and procedures.

Physicians increasingly hold financial investments in labs that perform tests and medical facilities that provide treatment and care. Studies show that doctors with such ownership interests order two to four times as many tests and charge perhaps two-thirds more than do non-self-dealing physicians.¹³⁶ A *Wall Street Journal* investigation reported that “in many cases the physicians earn 25 percent to 100 percent and more a year on investments of \$5,000 to \$100,000.”¹³⁷

A 1991 study by the state of Florida found that at least 40 percent of the practicing doctors in the state have invested in health care facilities to which they can refer patients. In the case of diagnostic-imaging centers, the study found that doctors own 93 percent of such facilities. In addition, the study reported that the number of tests per patient is almost twice as great in doctor-owned labs than in those not owned by doctors. Likewise, the average per patient charge in a joint venture facility was more than twice the charge in a non-joint venture lab.¹³⁸ The study concluded that these ownership arrangements have led doctors to order unnecessary tests and questionable treatments in order to increase their profits.

The Consumer Federation of America (CFA) reported similar findings in a review of studies of doctor ownership of diagnostic testing facilities. The CFA report concluded, “The rapid spread of physician ownership of diagnostic testing facilities is a much more likely cause of rising diagnostic costs than defensive medicine.”¹³⁹ The report found that the number of physician-owned labs increased nearly four-fold during the 1980s.¹⁴⁰ Moreover, it determined, physicians own or have compensation arrangements with one-third to one-half of all clinical labora-

tories.¹⁴¹ In the field of Magnetic Imaging Centers, physician ownership was found to exceed 50 percent. Reviewing other studies of physician ownership of labs, the report also noted that:

- Self-dealing physicians ordered 34 to 96 percent more tests than those who ordered tests at independent labs;
- Prices were 2 to 38 percent higher at physician-owned labs than at independent labs; and
- The total bill was 26 to 125 percent higher for physician-owned labs.¹⁴²

Inspector General Richard P. Kusserow of the U.S. Department of Health and Human Services made a “conservative estimate” that 25 percent of the clinical laboratories nationwide are owned by referring physicians. “Because physician investors can benefit financially from their referrals, unnecessary procedures and tests may be ordered or performed, resulting in unnecessary . . . expenditures,” said Kusserow.¹⁴³

A 1986 report by the Harvard University School of Public Health reached a similar conclusion: “Our data suggest that for certain high-profit, high-cost tests, there may be increased use in fee-for-service as compared with prepaid practices. The method of payment itself seemed to influence test use.”¹⁴⁴

And the Congressional Budget Office warned that, “any reductions generated by a different malpractice system might be offset by an increase in other medical services — including high-risk ones — either for therapeutic reasons or as a response to reductions in physicians’ income.”¹⁴⁵

Even the very consulting firm that the AMA commissioned to do its malpractice study, Lewin-VHI, admits that quantifying “defensive medicine” is a problematic exercise. “[D]efensive medicine is a difficult concept to define,” says the Lewin-VHI report. “There are a variety of reasons why a physician might perform services that are not warranted, including financial incentives, patient expectations, and lack of current clinical information. The wide range of potential motives, which are also likely to overlap in many cases, make it virtually impossible to isolate the contribution of defensive medicine costs.”¹⁴⁶

And, most recently, the architect of the “managed care” proposal that is at the core of President Clinton’s health care plan noted, “Right now, providers — hospitals, doctors and other practitioners — work in a system in which everyone is rewarded for providing more, not necessarily better, care.”¹⁴⁷

Despite the glaring ethical conflicts-of-interest posed by physician-ownership of medical labs, and their considerable role in promoting unnecessary tests and procedures, the medical profession has not aggressively attacked this source of wasteful medical care.¹⁴⁸ Betraying its trade association motivation, the AMA has vehemently opposed federal legislation to curb such conflicts-of-interest.¹⁴⁹

Finally, it is critical to note that restrictions on the legal rights of malpractice victims will have no effect upon the alleged practice of “defensive medicine.” According to a review of cesarean sections, a procedure which is routinely said to be performed because of physicians’ fears of malpractice suits, tort restrictions in California and other states have not reduced the use — or misuse — of c-sections when compared to states without such restrictions.¹⁵⁰

In the hands of unscrupulous physicians, “defensive medicine” is a form of financial malpractice, a “rip-off” of consumers. As practiced by law-abiding physicians, it is the delivery of thorough, high quality medical care.

The malpractice laws are an ally in the consumer’s search for the best possible medical care — not only because the possibility of a lawsuit encourages prudence, but also because malpractice litigation often leads to actions that save countless other lives by deterring unsafe practices and by pinpointing recidivist medical malpractice practitioners.

