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Book Review [A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation]

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BOOK REVIEW

A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation, By Paul C. Weiler, Howard H. Hiatt, Josephine P. Newhouse, William G. Johnson, Troyen A. Brennan & Lucian L. Leape. Cambridge, MA: Harvard University Press. 1993. Pp. 175. Hardcover. \$29.95.

*Reviewed by Melvyn D. Silver**

Does medical malpractice tort litigation actually result in improved medical care? If so, is the burden of the cost of that type of litigation upon our medical and legal system worth it? And, whether the answer is yes or no, is there possibly a better way to provide compensation for those suffering medical injury? These are the questions that led to the commission of the Harvard Medical Practice Study in 1988. The study team included Paul C. Weiler, Professor of Law at Harvard Law School; Howard H. Hiatt, Professor of Medicine at Harvard Medical School; Joseph P. Newhouse, Professor of Health Policy and Management at Harvard Medical School and Kennedy School of Government; William G. Johnson, Professor of Health Economics at Arizona State University; Troyen A. Brennan, Professor of Law and Public Health at Harvard School of Public Health; and Lucian L. Leape, Abjunct Professor at Harvard School of Public Health. Together, the team of doctors, lawyers, economists, and statisticians set out to investigate what was actually happening to patients in hospitals and to doctors in courtrooms. The story behind the study, and the impressive results it achieved, are chronicled

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in *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation*.¹

A Measure of Malpractice is divided into three separate sections and seven chapters. The first section discusses the malpractice setting and the policy debate about medical malpractice.² The second section examines the epidemiology of medical injury, and patient injury and malpractice litigation.³ The third section examines patient losses and compensation, and medical malpractice litigation and injury prevention.⁴ Finally, the authors discuss their own feelings in a section aptly called "Ruminations for the Future."⁵

The idea for the study was conceived in 1984 by then-Deans Howard Hiatt of the Harvard School of Public Health and James Vorenberg of the Harvard Law School, both of whom were concerned over the mounting personal and economic costs of the medical malpractice system.⁶ As membership in the group grew, so did the awareness that a serious study in the area of medical malpractice was needed. The group recognized that the controversies surrounding medical malpractice tort reform legislation before the legislatures of New York and Massachusetts in 1988 "rested almost entirely on anecdotal evidence too easily tailored to the predisposition of the protagonist."⁷ The authors further recognized that, with the exception of a study on the incidence of medical injury in California in the mid-1970's, no detailed study existed concerning the incidence of medical injury that would permit legislatures to make informed decisions on this serious issue.⁸ The issue was serious not only because of the costs to the public resulting from the administration of a tort system involving medical injury, but also because of the cost of medical malpractice insurance to doctors—a cost that was, by necessity, being passed on to the consuming public by the practicing physician.⁹

1. PAUL C. WEILER, ET AL., *A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION* (1993).

2. *Id.* at 1-32.

3. *Id.* at 33-76.

4. *Id.* at 77-134.

5. *Id.* at 135-152.

6. *Id.* at vii.

7. *Id.* at viii.

8. *Id.*

9. *See id.* at 2.

In preparation for the study, the group sought support from its home state of Massachusetts.¹⁰ Massachusetts, however, denied the team the funding it needed.¹¹ The legislature had proposals before it at the time the study was being formed, and this legislature was not interested in a study that might produce a factual basis for serious litigation but simultaneously derail proposals currently before it.¹² As the democratic process plodded forward in Massachusetts, however, the State of New York stepped forward and provided the necessary support.¹³ Through the support of the New York governor and Dr. David Axelrod, Commissioner of Health of New York, a four-million-dollar amendment was attached to New York's pending malpractice reform bill to allow the study to go forward.¹⁴ Dr. Axelrod recognized the significance the study could have for the state of New York. In 1988, he estimated that New York doctors and hospitals were spending approximately one billion dollars annually for malpractice insurance.¹⁵

Section one describes the primary steps the group took prior to engaging in its empirical study of New York's medical malpractice system.¹⁶ As a foundation for the study, and as a manner of framing the problem that New York faced, the team examined New York's system in terms of malpractice insurance, claims frequency, and length of time from injury to payment. The authors note that in New York, the average doctor paid \$360.00 (in 1990 dollars) for liability coverage in 1949; \$1,000.00 in 1965; \$7,300.00 by 1975; and by the end of the 1980's, almost \$40,000.00 per year.¹⁷ Some doctors in high-risk fields such as obstetrics paid almost \$200,000.00 per year.¹⁸ The authors state that these malpractice premiums are not unusual, but are similar to those charged in states such as Florida, Michigan, and Illinois.¹⁹ These premiums were highlighted in the initial "malpractice crisis" that

10. *Id.* at viii.

11. *Id.*

12. *Id.* at viii-ix.

13. *Id.* at ix.

14. *Id.*

15. *Id.*

16. *Id.* at 1-32.

17. *Id.* at viii.

18. *Id.*

19. *Id.*

occurred in the mid-1970's, followed by a second crisis in the mid-1980's.²⁰ During each of these periods, insurance rates rose dramatically.²¹ The authors anticipate that the trend will continue in the 1990's.²²

During this same time period, the authors note that claims frequency, as measured by the number of claims per doctor per year, also rose from just over one claim per one hundred doctors per year in the late 1950's to well over ten claims per one hundred doctors in the mid-1980's.²³ The average payment made on successful claims rose from \$40,000.00 (in 1990 dollars) in 1970 to nearly \$150,000.00 by the end of the 1980's.²⁴ Individual malpractice awards that captured the attention of the public (as well as that of the insurers and legislatures) included a \$52,000,000.00 malpractice verdict in Houston in 1988, a \$54,000,000.00 verdict in Los Angeles in 1989, a \$78,000,000.00 award in Chicago in 1990, and a stunning \$127,000,000.00 award against an Illinois ophthalmologist in 1991.²⁵ While the authors point out that these are inordinately high awards, they indicate that these awards form much of the basis of the anecdotal evidence used by legislators, doctors, and insurers in pressing the case for malpractice tort reform litigation.²⁶

The authors indicate that malpractice litigation is not as rewarding as it may seem. The median time from injury to claim is thirteen months, and from claim to payment is twenty-three months, a total of three years.²⁷ The study found that claims for the most serious injuries, generating the greatest financial hardships for the patient, averaged six years to conclusion in New York—and at times, more than a decade.²⁸ Even after such lengthy time periods, only about half of the patients who filed claims ultimately received any payment at all.²⁹ Most tragic, as the authors point out, is the fact of life known to all attorneys practicing in the field of

20. *Id.* at 3.

21. *Id.*

22. *Id.*

23. *Id.* at 4.

24. *Id.*

25. *Id.* at 5.

26. *Id.* at 5.

27. *Id.*

28. *Id.*

29. *Id.*

medical malpractice: "partly because of the delay factor just mentioned, the most severely injured victims—those with the greatest needs for immediate relief—settled their claims for the smallest proportion of their actual losses."³⁰

Thus, as the authors prepared to enter the detailed phase of their study, they noted that approximately seven billion dollars a year in premiums and self-insurance were part of the medical malpractice system.³¹ This figure was separate and apart from the economic and psychological burdens placed on providers and payors in the health care system, and still separate from the injuries suffered by those affected by medical malpractice.³²

The scope of the study was the broadest yet undertaken on the subject. The team sifted through 30,000 hospital records, tracked down and interviewed 2,500 patients, surveyed 1,000 doctors, and examined nearly 70,000 malpractice claims filed in New York between 1975 and 1989.³³ Needless to say, hospitals and physicians participating in the study did not want evidence of malpractice that might be uncovered to be revealed to patients.³⁴ The team therefore chose 1984 as the study year, a time when New York's thirty-month statute of limitations would have run.³⁵ In terms of patients, the subjects interviewed included both medically injured patients and a match control group who had not been injured during treatment.³⁶ The patients were not informed that the study involved tort reform or medical malpractice.³⁷ Instead, the subjects were told the study concerned "the economic consequences of hospitalization."³⁸ As a further control, the interviewers themselves were unaware that any of the patient subjects might have been injured at all, or that the subject of the study was related to the issue of malpractice.³⁹

In its empirical investigation, the Harvard team examined what New York's medical and legal systems were ac-

30. *Id.*

31. *Id.* at 11.

32. *Id.*

33. *Id.* at 10.

34. *Id.* at xi-xv.

35. *Id.* at xi.

36. *Id.* at xii.

37. *Id.*

38. *Id.*

39. *Id.*

tually doing with respect to medical injuries, rather than what they should be doing.⁴⁰ In a discussion of the tort system, the authors noted the significant change that had occurred in who pays. Where the tort system was originally designed to punish the negligent actor, from which the negligent actor would learn to improve his actions, such "punishment" is now paid by a liability insurer.⁴¹ Given that insurers pay the liability claim, and the doctor personally does not, is there a justification for the tort system improving medical care? In effect, has the occurrence of liability insurance changed the entire rational basis for a tort malpractice system?

The authors note that in a great number of cases, if not all cases, the patient's subsequent medical bills are also paid by insurance—whether through Medi-Cal, Medicaid, a different state program, or a private insurer.⁴² While the patient suffers the result of the injury, the personal economic loss from medical bills is substantially lessened. Through social security disability payments, state disability payments, long-term disability insurance, and other possible income replacement programs, much of the income loss to the disabled worker has also been compensated. These developments raise the question of whether the functions and initial purposes of the tort malpractice litigation system have been outdated. All of this information must be considered in light of the fact that when a successful malpractice award is received, only about forty percent of the total amount expended in the claims process actually reaches the injured patient.⁴³ That total amount includes legal defense costs, as well as the plaintiff's attorneys' fees and costs.⁴⁴

In its consideration of the possible weaknesses of New York's system, the team discussed the alternative system of no-fault compensation, such as is practiced in New Zealand and Sweden.⁴⁵ Under a no-fault scheme, all iatrogenic injuries (injuries induced by medical injuries that prolong the patient's hospital stay), whether or not a result of medical negli-

40. *Id.* at 13.

41. *See id.* at 15.

42. *See id.*

43. *Id.* at 17.

44. *See id.*

45. *Id.* at 19-26.

gence, would theoretically be eligible for compensation.⁴⁶ The authors engage in a detailed statistical study that is most illuminating. Included in this discussion is whether such a system would be affordable and whether it can be administered properly.⁴⁷ Noting that a no-fault model in worker's compensation expends roughly twenty percent of the claims dollar on administration (compared to sixty percent in malpractice), the authors also note that the two systems are not quite comparable.⁴⁸ In worker's compensation situations, a worker presumably reports to work healthy and leaves injured.⁴⁹ Causation usually is a factor. On the other hand, a patient generally enters a hospital already ill, and becomes "illier."⁵⁰ Determining whether the additional increment in illness or injury was caused by the hospital or was simply a logical continuation of the patient's illness is not always simple.⁵¹

A better analogy might be to attempt to determine, in the worker's compensation system, whether a disease for which the injured worker seeks compensation is an "occupational disease" or one occurring outside the work environment. The advantage of the no-fault system is that once it is determined that an iatrogenic injury has occurred, fault need not be addressed.⁵² Fault should be discovered, however, for the purpose of improving the quality of medical care.⁵³ Here, physician judgment is necessary—and if it is the physicians at a local institution judging each other, can this judgment be relied upon? What is the actual magnitude of the problem? How much medical treatment actually results in iatrogenic injury?

The authors note that the prior California study of 20,000 hospital records in 1974 found adverse events occurred in 4.65% (1 in 21) of all hospitalizations, and negligent adverse events (or potentially litigable events) occurred in .79% (1 in 125) of hospitalizations.⁵⁴ The prior study found

46. *Id.* at 23.

47. *Id.* at 27-30.

48. *Id.* at 29.

49. *Id.* at 23.

50. *See id.*

51. *Id.*

52. *Id.*

53. *See id.* at 24-25.

54. *Id.* at 36.

that one of every six iatrogenic injuries resulted from negligent medical practice.⁵⁵ What could the result be in New York? The authors devised a detailed study system for the review of the approximately 30,000 potential medical claims that could occur in New York.

Fifty-one different hospitals throughout the State of New York were selected, with 31,000 records reviewed relative to the 2.6 million people hospitalized annually in New York.⁵⁶ Teams of medical research analysts and physicians travelled to each hospital to review the records.⁵⁷ Virtually every record requested was ultimately found by the hospital and provided for review.⁵⁸ Indeed, what is remarkable to a practicing litigator such as this reviewer is the fact that for the purpose of this type of study, the hospitals were able to supply such complete records. Those involved in litigation will note the difficulty hospitals always seem to claim in producing records when involved in actual litigation. What a difference the purpose of the request for records obviously makes. Where there were differences between two reviewers on important issues, the file was reviewed yet again by a senior physician.⁵⁹ In the end, over 96% of all records sought were obtained in full.⁶⁰ The results were striking. Of the 30,195 records actually reviewed, 1,278 adverse events occurred as a result of medical management during the hospitalization.⁶¹ Three hundred and six injuries were the result of provider negligence.⁶² After eliminating certain adverse events for statistical purposes, the authors ultimately analyzed 922 injuries that they could "positively identify as resulting from care provided at one of our hospitals."⁶³ For the risk factor analysis, the authors utilized all 1,278 events.⁶⁴ The result was that the incidence of adverse events suffered by hospitalized patients was 3.7%.⁶⁵ Of these events, 27.6% were due to medical negligence; in essence, one percent of all patients

55. *Id.*

56. *Id.* at 40.

57. *Id.* at 41.

58. *Id.* at 42.

59. *Id.* at 41.

60. *Id.* at 42.

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.* at 43.

hospitalized suffered a negligent medical injury.⁶⁶ These figures were remarkably similar to those compiled in California a decade earlier.⁶⁷ An adverse medical event occurs in approximately 4% of all hospitalizations, and one-quarter of these events involves substandard care.⁶⁸ Getting past statistics and into real life, the numbers are frightening. The authors note that among the 2.6 million patients discharged from New York hospitals in 1984, nearly 99,000 suffered disabling injuries.⁶⁹ Of these, 56,000 produced minimal impairment, from which patients recovered within one month,⁷⁰ and 13,500 led to impairment with recovery in less than six months.⁷¹ Still, 3,800 patients had serious injuries, where permanent impairment caused a disability level ranging up to fifty percent; another 2,500 suffered severe to total disability.⁷² Most frightening of all, 13,400 New York patients died in 1984 as a result of medical treatment.⁷³ Thirty-four percent of the adverse events that led to permanent total disability were due to substandard care, as were fifty-one percent of the deaths from adverse events.⁷⁴ Two-thirds of the injuries produced by grave negligence were fatal, six times the mortality rate from non-negligent iatrogenic injuries.⁷⁵ Projecting the statistics across the nation, assuming the New York model holds true in all other states, more people die from iatrogenic injury than from any other cause, including motor vehicle accidents and cardiac events.⁷⁶ The authors state:

If New York's adverse-event-related death total can be extrapolated to the U.S. population as a whole, one would estimate over 150,000 iatrogenic fatalities annually, more than half of which are due to negligence. Medical injury, then, accounts for more deaths than all other types of accidents combined, and dwarfs the mortality associated with

66. *Id.*

67. *Id.*

68. *Id.*

69. *Id.* at 43-44.

70. *Id.* at 44.

71. *Id.*

72. *Id.*

73. *Id.*

74. *Id.* at 45.

75. *Id.*

76. *Id.* at 55.

motor vehicle accidents (50,000 deaths per year) and occupation-related mishaps (6,000 deaths per year).⁷⁷

Had the authors stopped here, the need for the study would have been justified. In chapters four⁷⁸ and five,⁷⁹ the Harvard team correlates the results of their study with the legal system. In particular, the authors ask these pertinent questions: How many malpractice cases were being brought? How many of those involved provider negligence? Were legislative mandates (such as shorter and tighter statutes of limitations, procedures for claims screening and certification, and restriction on the size of contingent fees) valid? Malpractice litigation was reviewed with evidence provided through the New York Department of Health and New York's liability insurance carriers.⁸⁰ Patricia Danzon's 1974 California study, which reviewed medical malpractice claims between 1975 and 1978 in California and elsewhere, was reviewed.⁸¹ Danzon found that for every ten negligent adverse events (torts) within the California health care system, only one medical malpractice claim was lodged.⁸² Only forty percent of those claims ever received any payment through the legal system.⁸³ How did Danzon's study compare ten years later in New York? The Harvard study found that the frequency of claims rose from six per one hundred physicians in 1976 to seven per one hundred physicians in 1984.⁸⁴ In spite of this increase, if the Danzon study were true, then there would not be an excess of malpractice litigation, but rather an actual "malpractice gap"—too few malpractice claims being filed!⁸⁵ After reviewing the number of claims actually filed against physicians, and the number of doctors who were actually negligent, the authors concluded that:

[O]ur investigation of the incidence and distribution of litigation in New York demonstrates that while the legal system does in fact operate erratically, it hardly operates excessively. Indeed, precisely because so many claims

77. *Id.*

78. *Id.* at 61-76.

79. *Id.* at 77-110.

80. *Id.* at 61.

81. *Id.* at 62-63.

82. *Id.* at 62.

83. *Id.*

84. *Id.* at 69.

85. *Id.* at 69-73.

brought by patients are misdirected, earlier comparisons of the totals of negligent injuries and malpractice claims actually disguised how small are the odds that a potentially legitimate tort claim will be brought.⁸⁶

Although a substantial majority of malpractice claims filed by patients do not flow from truly negligent injuries, the authors note that the legal system does a surprisingly accurate job of sifting valid from invalid claims.⁸⁷ One question, of course, is how to protect innocent doctors from invalid claims, and to assure that more valid claims than invalid claims are filed.⁸⁸ The authors note that the chances that any one doctor will be sued are far greater if negligent treatment has occurred than if it has not.⁸⁹ The litigation process often serves as a discovery process, in the plaintiff's attempt to obtain the records and files to determine whether a negligent event occurred. By contrast, this study provided to the Harvard reviewers all of the information not otherwise easily obtainable by a plaintiff at the commencement of litigation. These reviewers thus had the advantage of hindsight in determining whether negligence occurred, but the plaintiff at the initiation of litigation has only an estimate of negligence by foresight. In the end, a much greater ratio of injured patients do not sue than do sue.⁹⁰ Even after controlling for those patients injured as a result of medical negligence but whose injuries were slight and whose recoveries occurred in a short period of time, the Harvard team found as follows:

But even after controlling for this factor, 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.⁹¹

If malpractice litigation's goal is to provide compensation for the injured victim, and to draw the tortfeasor's error to his attention so that he may learn thereby, how effective is that

86. *Id.* at 73.

87. *Id.* at 75.

88. *Id.*

89. *Id.*

90. *Id.* at 76.

91. *Id.*

system? If the primary aspect is to provide compensation for the injured person, is this system effective?

The authors note that the overwhelming number of injuries are short-term. Within six months, sixty-three percent of persons suffering iatrogenic injuries had returned to work.⁹² The medical costs and wage losses for these victims generally came to less than \$4,000.00 in each category over that time period.⁹³ Again, while most iatrogenic injuries were minor, thirty-seven percent resulted in some sort of major disability.⁹⁴ If the purpose of any tort reform system is to bring compensation to these victims, how will this occur? The team looked at all sources of income: long-term disability income, short-term disability income, state disability income, Medicare, employer plans, community plans, welfare, charitable plans, and family help were all considered.⁹⁵ The authors also considered the effect of taxes.⁹⁶ The authors concluded that if any no-fault plan goes into effect, there must be a certain deductible period, such as a six-month waiting period.⁹⁷ However, the costs incurred in this period are relatively small—a two-month waiting period as opposed to a six-month waiting period would impose only \$42,000,000 in additional benefit payments in the New York plan that they propose as feasible, as against a total expenditure of one-billion-dollars—the same amount currently expended on medical malpractice insurance premiums.⁹⁸

However, would a no-fault system, even if it were able to compensate victims, result in injury prevention? And in considering the billion-dollar payment in a no-fault system that might be instituted in New York, is that truly a fair figure? The one-billion-dollar figure comes after patients have already paid for certain features of treatment on their own (through their own medical insurance, for example). This system requires that these other medical insurance costs and medical treatment costs be borne by the greater segment of society, outside of the plan. The authors wisely do not attempt to make any evaluation of this factor; it would un-

92. *Id.* at 92.

93. *Id.* at 96.

94. *See id.* at 92.

95. *Id.* at 77-109.

96. *Id.*

97. *Id.* at 101.

98. *Id.* at 102-03.

doubtedly entail a detailed study of the entire socioeconomic system of health care benefits in the United States. The Congress of the United States is embarking on such an undertaking at the present time.

In chapter six, the authors consider "malpractice litigation and injury prevention." In this regard, the authors interviewed physicians who had been the subject of malpractice claims, and who had a fear of malpractice claims.⁹⁹ They considered what effect the fear of a malpractice claim had upon their actual practice.¹⁰⁰ They also considered hospitals in which a greater number of claims had been brought, particularly whether those hospitals had instituted better medical control of procedures, and better medical practice in general.¹⁰¹ In effect, did the tort system work?

The authors note that malpractice litigation is directed toward *enforcing* rather than *defining* the appropriate standard of physician care.¹⁰² It penalizes physicians who deviate from the standard of care.¹⁰³ No effort is made to actually define the standard of care; the physician is simply compared against that standard of care in the community.¹⁰⁴ To consider whether the fault system would have a greater effect than the no-fault system, the authors were limited to a consideration of the no-fault automobile insurance system in the Province of Quebec.¹⁰⁵ It was a full tort-replacement scheme, in which no-fault was applied regardless of the severity of injury (by contrast, most American jurisdictions that have no-fault allow suit if the injury is serious or disabling).¹⁰⁶ Amazingly, research on the preventive effect of the Quebec program showed that there was an appreciable increase in fatal injuries after no-fault took effect, although no one is quite sure why this occurred.¹⁰⁷

The physician survey was most interesting. Seven hundred and thirty-nine physicians were interviewed personally

99. *See id.* at 111-134.

100. *Id.*

101. *Id.*

102. *Id.* at 113.

103. *Id.* at 113-14.

104. *See id.*

105. *Id.* at 116.

106. *Id.*

107. *Id.*

or by survey.¹⁰⁸ Doctors were asked to rate malpractice litigation as an influence for maintaining or enhancing the quality of medical practice.¹⁰⁹ Doctors do systematically overestimate the risk that malpractice actions will be brought against them.¹¹⁰ In the low-risk group of doctors (e.g., internists), doctors perceived their risk of being sued for malpractice as four times higher than it actually was; in the medium-risk group (e.g., general surgeons), the perception was twice as high as the reality; and in the high-risk group (e.g., obstetricians), the perceived risk was 1.6 times greater than the actual risk.¹¹¹ Did the doctors modify their care based upon their anecdotal assumption of suit?

In the written survey, the doctors did not rate the threat of malpractice litigation as a very highly motivating factor in providing improved medical treatment.¹¹² Research journals and seminars provided a greater incentive.¹¹³ But in personal interviews, doctors revealed that the threat of malpractice litigation had the most pronounced impact on their practice patterns.¹¹⁴ The doctors rated as a high factor the positive reinforcement of professional colleagues as a significant factor in their practice.¹¹⁵ A malpractice suit, which by its very nature tends to tarnish the reputation of the physician, had a severe, psychologically disabling affect upon the physician.¹¹⁶ The threat of malpractice litigation was indeed a significant factor. The conclusion based upon statistical study found that at the present claims intensity level of malpractice litigation, the New York State negligent injury rate is .89% of admissions.¹¹⁷ The injury risk would rise to 1.2% if there were no medical malpractice claims activity.¹¹⁸ In effect, "the current level of litigation intensity in New York appeared to be reducing the negligent injury rate in our sample by twenty-nine percent . . . and overall medical injures by

108. *Id.* at 118.

109. *Id.* at 118-19.

110. *Id.* at 124.

111. *Id.*

112. *Id.* at 126.

113. *Id.* at 128.

114. *Id.* at 128-29.

115. *Id.* at 124.

116. *Id.* at 126.

117. *Id.* at 131.

118. *Id.*

eleven percent”¹¹⁹ Malpractice litigation does indeed have an injury-prevention effect. The authors conclude as follows:

[C]onsequently, if the malpractice law in New York were repealed and all providers fully insulated against suit, the predicted increase in medical injury rates would be even greater than the rate stated earlier, 11% However ill-suited it may be as a vehicle for delivering compensation to people who are already injured, the litigation system seems to protect many patients from being injured in the first place. And since prevention before the fact is generally preferable to compensation after the fact, the apparent injury prevention effect must be an important factor in the debate about the future of the malpractice litigation system.¹²⁰

And this, my good readers, comes from the mouths of physicians. This is a book that many doctors will not like. Anecdotal evidence dies hard. Finally, in chapter seven, the Harvard team “ruminates” about the future.¹²¹ In the utilization of a no-fault system, the authors assume that the current one billion dollars paid in malpractice premiums in New York might better be distributed among the actual iatrogenically injured persons in New York.¹²² Again, this includes those suffering medical injury not as a result of any negligence but simply as a result of an unexpected or unintended event, as well as those suffering injury from medical negligence.¹²³ The authors discuss plans abroad, and obviously have a hard time balancing a no-fault system against the current system, which they would like to see modified. The authors note that:

[A]fter devoting a great deal of thought and effort to this inquiry, our best judgment is that the threat of malpractice suits does somewhat reduce the risk of patient injury. On the basis of the point estimate discussed in chapter 6, taken at face value, the current intensity of tort litigation in New York appears to be reducing the aggregate injury rate there by approximately 10 percent.¹²⁴

119. *Id.*

120. *Id.* at 133.

121. *Id.* at 135-152.

122. *Id.* at 141-42.

123. *Id.* at 141.

124. *Id.* at 144.

The authors note that the prior California study indicated that the tort system would pay for itself if it reduced negligent injury rates by twenty percent or more.¹²⁵ The authors note that their studies indicate that *negligent* injury rates were reduced by twenty-nine percent as a result of the malpractice litigation in New York, and “would comfortably pass the Danzon test.”¹²⁶ The authors further state that the “injury prevention estimate is in fact likely to be low because of the assumption that areas in the state with zero litigation rates faced zero legal liability.”¹²⁷ All in all, this surprisingly short book is direct and to the point. The study methodology was reviewed and carefully constructed. The authors appeared to have no preconceived notion as to what the result would be, and from their choice of words, indeed appeared surprised to find that the tort system actually worked in the area of medical negligence. Interestingly, this reviewer’s impression is that the tort system worked because of physicians’ personal fear of suit than because of the fact that suit was brought in cases of actual medical negligence. This is a book that should be carefully reviewed by our own state legislature before they engage in any tort reform crusade. However, to seriously expect that our legislature will accept these facts above anecdotal evidence, any more than our local physicians or tort bar will, is to ask too much. Relaying the results of this book—that a team significantly comprised of physicians found that the tort system is effective and perhaps should be maintained—will probably in time become nothing more than anecdotal itself.

125. *Id.* at 134.

126. *Id.*

127. *Id.*