



# Legislative Budget and Finance Committee

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## – Agenda –

### Legislative Budget and Finance Committee Public hearing pertaining to Senate Resolution No. 20

8E-B Capitol East Wing  
June 25, 2019 at 9:00 AM

- I. **Welcome by Senator Mensch**
- II. **Panel I – Patients**
  - Patient Safety Authority
    - Ms. Regina M. Hoffman, MBA, RN | Executive Director, Patient Safety Authority
  - Questions from the Committee
- III. **Panel II – Providers**
  - Hospital and Healthsystem Association of Pennsylvania:
    - Mr. Warren Kampf | Senior Vice President for Advocacy and External Affairs
  - Pennsylvania Medical Society:
    - Dr. Danae Powers | President, PA Medical Society
    - Mr. Peter J. Hoffman | Esquire, Eckert Seamans Cherin and Mellott, LLC
  - Questions from the Committee
- IV. **Panel III – Attorneys**
  - PA Association for Justice:
    - Ms. Lisa Benzie | Esquire, Plaintiff Bar
    - Mr. Timothy Lawn | Esquire, Plaintiff Bar
  - Pennsylvania Bar Association:
    - Ms. Katherine B. Kravitz | Esquire, Defense Bar
    - Mr. Eric J. Purchase | Esquire, Plaintiff Bar
  - Questions from the Committee

*“Providing members of the Pennsylvania General Assembly timely, accurate, and unbiased information, analysis, and performance evaluation to inform their policy decisions.”*

# Patient Safety Authority Testimony to the Legislative Budget and Finance Committee Senate Resolution 2019-20

Prepared and Presented by  
Regina M. Hoffman  
Executive Director  
Patient Safety Authority

# Position

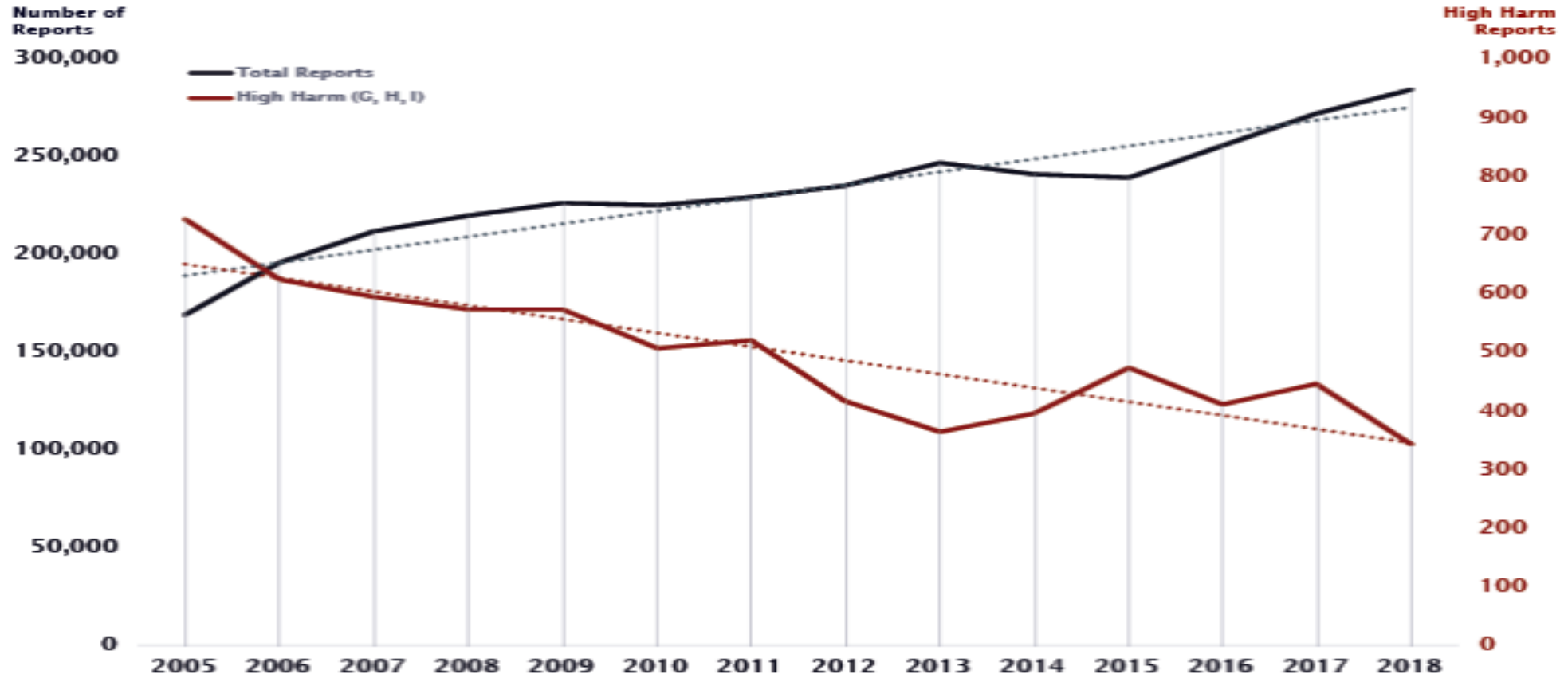
- The Patient Safety Authority neither supports nor opposes a change in venue for medical malpractice cases in Pennsylvania.
- The Patient Safety Authority is interested in providing the committee with facts associated with the data it collects.

# Background

- Pursuant to Act 13 of 2002, Pennsylvania acute care facilities are mandated to report patient safety events. Reporting began in June 2004.
- Facilities are required to report both Incidents and Serious Events to the Patient Safety Authority.
- Incidents - an event, occurrence, or situation involving the clinical care of a patient in a medical facility which could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional healthcare services to the patient.
- Serious Event - an event, occurrence, or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional healthcare services to the patient.
- High Harm Event – a subcategory of serious events that result in permanent harm to the patient, immediate threat to life, or death.
- *Note – the term Medical Error does not appear in any of these definitions.*

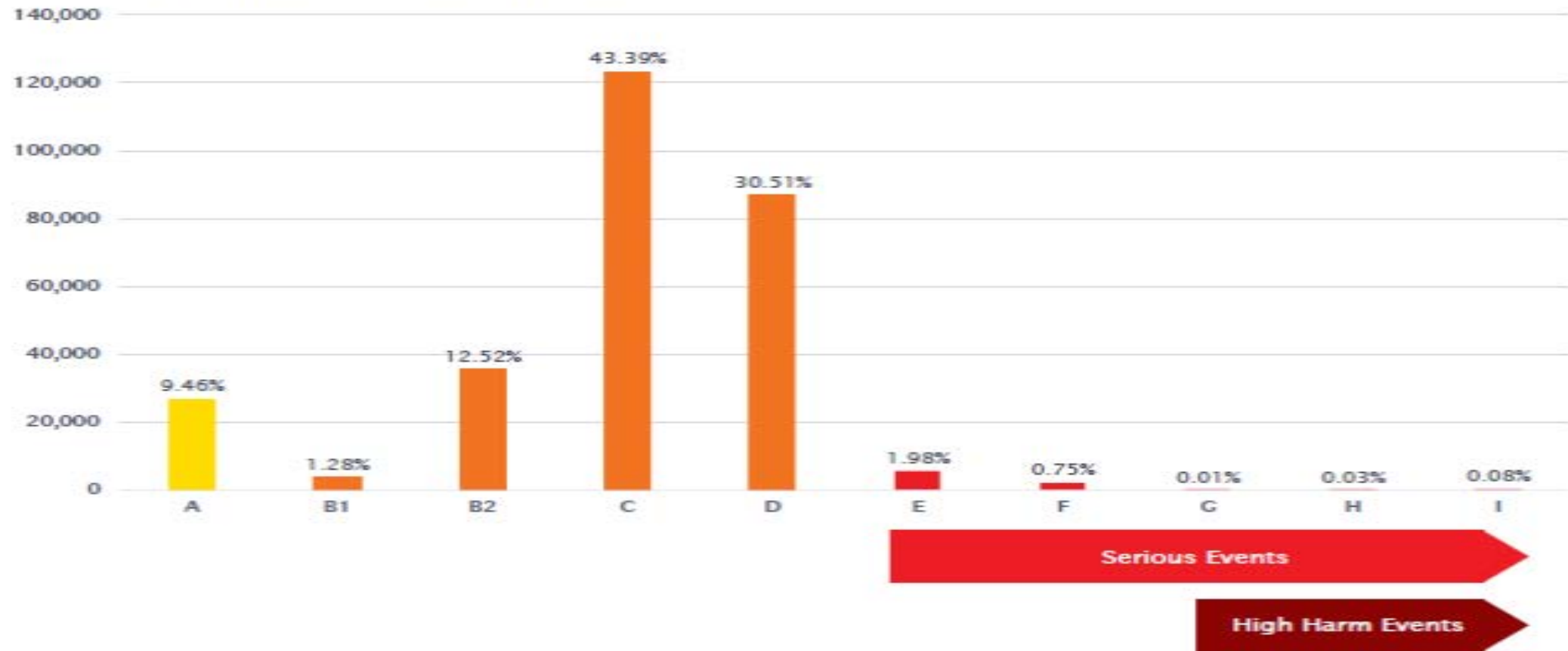
# Reports 2005-2018

Total Reports and High Harm Reports



# Reports by Harm Score (2018)

Percentage of Reports by Harm Score (2018)



# Conclusions

- Fact – The number of total *reports* has increased since 2005.
- Fact – The number of high harm *reports* has decreased since 2005.
- Fact – Pennsylvania has the largest number of patient safety events reported across the country because the legislature had the foresight to include all events, including non-harm events in its mandatory reporting requirements.
- Fact – There are limitations to Patient Safety Authority data. Even with mandatory reporting requirements, not all events are captured or submitted. Therefore, our numbers do not represent 100% of patient safety events.
- Fact – Low numbers of reports does not mean care is safer, in fact, low numbers of reports is generally viewed as a patient safety concern in the industry.
- Fact – While the total number of *reports* has increased, we cannot conclude that the total number of actual *events* has increased. We also cannot conclude with certainty that because the number of high harm reports decreased that the actual number of patient events decreased.
- Our opinion - The Patient Safety Authority views an increase in the total number of events and a decrease in high harm events as a positive signal for the people of Pennsylvania. We expected the total number of reports to increase over time due to education related to the requirements, regulatory pressure and culture change. When organizational culture supports reporting, more opportunities are uncovered to improve care and processes before harm occurs, so one would expect that when reports of non-harm go up and organizations address the underlying issues, that reports of actual harm should go down.

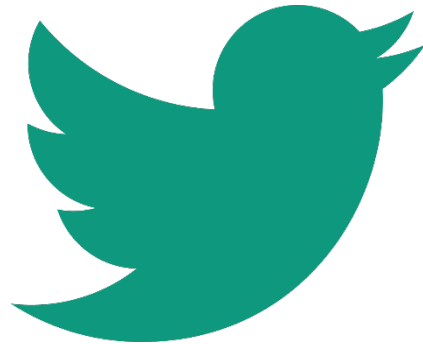
# What questions do you have?



# Thank You!



@PennsylvaniaPatientSafetyAuthority



@PAPatientSafety



Pennsylvania Patient  
Safety Authority



Pennsylvania Patient  
Safety Authority



The Hospital + Healthsystem  
Association of Pennsylvania

*Leading for Better Health*

Statement of The Hospital and Healthsystem Association of Pennsylvania

For the

Legislative Budget and Finance Committee  
A Joint Committee of the Pennsylvania General Assembly

Presented by  
Warren Kampf

Harrisburg, Pennsylvania  
June 25, 2019

My name is Warren Kampf and I am the Senior Vice President for Advocacy and External Affairs for The Hospital and Healthsystem Association of Pennsylvania, or HAP. HAP advocates for approximately 240 member organizations across the commonwealth, as well as for the patients and communities they serve.

HAP appreciates the opportunity to provide comments to the Legislative Budget and Finance Committee to assist in the preparation of a report evaluating the proposed changes to the Pennsylvania Supreme Court's Rules of Civil Procedure that would repeal medical professional liability venue reforms adopted during 2002.

Pennsylvania physicians and hospitals—and, most importantly, health care consumers—would be adversely affected by such a rule. By allowing venue selection in counties with little relation to the underlying cause of action, the trial bar could shop for verdict-friendly venues in which to file their suits. This would again lead to higher premiums for medical liability insurance, make Pennsylvania less attractive to physicians considering practicing in the state, increase medical costs, and adversely impact access to care for consumers. The proposal is not in the public interest.

During my testimony today, I will provide general background about this issue and explain why the Supreme Court should not implement the proposed rule change.

As a result of the passage of the Medical Care Availability and Reduction of Error (MCARE) Act, both the legislature and the Supreme Court adopted reforms that reduced the number of malpractice claims brought in Pennsylvania, especially in Philadelphia and Allegheny Counties. This was accomplished, to some degree, by limiting venue for medical liability actions to the county "in which the cause of action arose." Previously, expansive venue rules allowed medical liability plaintiffs to sue defendants almost anywhere they did business, even if the alleged malpractice occurred elsewhere.

Even with these reforms, however, Pennsylvania remains—based on 2017 data—the third highest-cost state for insurance premiums on a per capita basis.



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The Civil Procedural Rules Committee of the Supreme Court now proposed late last year an amendment to the rules that limits venue in medical professional liability actions to the county in which the cause of action arose.

While HAP believes that patients injured during medical negligence should be compensated, HAP does not believe that a rule change is justified based on the explanation and limited data provided by the Civil Procedural Rules Committee around the proposed rule.

**The proposal does not acknowledge the changes to the health care system between 2003 and 2019, which could amplify the negative impact of the rule change, nor the obvious financial consequences of such a change.**

Changes to the health care delivery system that have taken place since the early 2000s include: hospital consolidations, workforce shortages, improvements to medical liability insurance availability, and escalating cost pressures.

- ***Mergers and consolidations:*** Since 2000, the number of hospitals affiliated with health systems has risen by 88 percent<sup>1</sup>. Because many hospitals that had been independent prior to the current venue policy are now affiliated with health systems, lawyers would have access to a much wider footprint of the state when shopping for plaintiff-friendly venues. For example, one Pennsylvania health system operates facilities within 18 counties.
- ***Worsening provider shortages:*** Based upon state-level projections of physician supply and demand performed by the U.S. Department of Health and Human Services' Health Resources and Services Administration, Pennsylvania will face a deficit of approximately 1,000 primary care physicians by 2025, or about 10 percent less than the estimated demand of more than 10,000 primary care physicians needed to serve Pennsylvania's population<sup>2</sup>. Rural areas are particularly vulnerable to losing providers given the disproportionate burden they face around statewide physician shortages.
- ***Medical liability insurance costs and availability:*** The impact of increased medical liability costs could cause closures of critical units, like obstetrics, which can inhibit adequate access to care. For example, between 1999 and 2000, median medical liability awards increased nearly 43 percent<sup>3</sup> and the average award for neurologically impaired infants

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<sup>1</sup>Hospital Consolidation: Longitudinal Trends of Pennsylvania's Independent and System-Affiliated General Acute Care Licensed Hospitals." HAP's 2018 analysis of Pennsylvania Department of Health, Division of Health Informatics' Annual Hospital Survey data, 2000 through mid-Q4 2017.

<sup>2</sup>Based upon state-level projections of physician supply and demand performed by the U.S. Department of Health and Human Services' Health Resources and Services Administration



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(\$1 million nationally during 2003) reached \$100 million in Philadelphia<sup>4</sup>. Not surprisingly, between 1999 and 2005, Pennsylvania saw a 17 percent decrease in obstetrics units<sup>5</sup>; after the venue rules changed, the number of staffed obstetric beds began to increase, expanding access once more. The increasing burden of the cost of medical liability insurance diverts critical resources from being reinvested into infrastructure and innovation.

A recent report by Milliman, which was prepared to evaluate the impact of the proposed change to the venue rule, shows that:

- The current average statewide medical professional liability (MPL) costs and insurance rates for physicians in Pennsylvania will likely increase by 15 percent<sup>6</sup>
- Many individual counties will likely see increases in physician MPL costs and rates of 5 percent, while counties surrounding Philadelphia will likely see larger increases of 45 percent<sup>7</sup>
- High-risk physician specialties, such as Obstetrics/Gynecology and General Surgery, will likely experience additional cost and rate increases of 14 percent above and beyond the increases stated above

Notably, the report explained that these projected increases are likely understated, as the analysis did not account for several additional items that could increase MPL costs and rates, including the impact of health care provider consolidation, uncertainty in pricing, and an increased incentive to bring smaller borderline claims. Simply put, any physician, other licensed professional or health system that can be sued in Philadelphia or other high-cost jurisdictions will need to be insured as if they practiced all the time in Philadelphia.

- ***Fiscal insecurity of today's hospitals, especially in rural areas:*** An analysis of Pennsylvania Health Care Cost Containment Council financial data indicates that, during 2018, more than a third (39%) of Pennsylvania's hospitals reported negative operating margins; among the commonwealth's rural hospitals, more than half reported negative operating margins. Keep in mind that while many of our hospitals are doing well, providing excellent care and in possession of state-of-the-art health care infrastructure, Medicaid only

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<sup>3</sup>Prepared statement of Shelby L. Wilbourn, MD, representing the American College of Obstetricians and Gynecologists, on "Patient Access Crisis: The Role of Medical Litigation," a joint hearing before the Committee on the Judiciary and the Committee on Health, Education, Labor, and Pensions (Senate Hearing 108-253) on "Examining the Status of Patient Access to Quality Health Care, Focusing on the Role of Medical Litigation and Malpractice Reform." 2/11/2003. Last accessed 1/24/2019.

<sup>4</sup>Ibid.

<sup>5</sup>HAP analysis of Pennsylvania Department of Health, Division of Health Informatics Annual Hospital Survey data, 1999 through 2005.

<sup>6</sup>Milliman Research Report, Review of Proposed Amendment of Pennsylvania Rules of Civil Procedure Nos. 1006, 2130, 2156, and 2179: Governing Venue in Medical Professional Liability Actions in Pennsylvania February 18, 2019, Thomas Ryan, Principal, FCAS, MAAA Carissa Lorie, Analyst

<sup>7</sup>Ibid.



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reimburses approximately 80 cents on the dollar of hospital costs, and Medicare reimburses at slightly below cost. Hospitals still provide three-quarters of a billion dollars in uncompensated care to the state's uninsured and those who cannot pay high deductibles. To offset higher medical liability coverage costs, hospitals will need to divert money from a wide range of operating and infrastructure needs, which may have a chilling effect on health care innovations. The health care ecosystem in hospitals is complex, costly, and in many locations, fragile; a venue change driven by lawyers on behalf of complainants may up-end that ecosystem in ways that truly affect access to care.

We were recently made aware of some arguments that suggest that since hospitals more and more frequently employ physicians, there is no risk of physicians limiting practice or leaving the state, because all costs will be borne by hospitals. As I stated just a minute ago, many, many hospitals manage the costs they have today at a seemingly insurmountable burden with government payors reimbursing well below actual costs. Adding massive liability insurance cost increases, whether imposed by a separate carrier or through self-insurance, would only make that situation far more serious. Further, just as hospitals have increasingly joined or become health systems themselves, a number of physician practices have sought to grow and conduct business in multiple counties, which means the venue change proposed will impact their financial prospects separately and distinctly from a hospital.

**Available data does not support the conclusion that the current venue rule should be rescinded.** The reduction of court filings of medical malpractice actions demonstrates that the tort reform measures enacted by the legislature and the Supreme Court are working.

Specifically, during 2002, the percentage of medical liability cases filed in Philadelphia represented 44 percent of all filings throughout the commonwealth. Of those reaching jury verdicts in Philadelphia during the period of 1999–2001, 41 percent yielded plaintiffs financial awards—a rate that is more than double the national average of 20 percent—and half of such verdicts exceeded \$1 million<sup>8</sup>.

By 2003, after enacting venue rule reform, filings in Philadelphia fell substantially and, during 2017, Philadelphia's cases accounted for 28 percent of the 1,449 filings statewide<sup>9</sup>.

Under the 2002 rule, however, patients can still bring medical liability suits, but such cases now must be tried in the jurisdiction where the alleged liability occurred. This 2002 reform did not deprive a claimant of the ability to access the courts to right a wrong. It only restricted where that case could be brought.

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<sup>8</sup>Bovbjerg RR and Bartow A. Understanding Pennsylvania's Medical Malpractice Crisis: Facts about Liability Insurance, the Legal System, and Health Care in Pennsylvania. Pew Charitable Trusts Project on Medical Liability in Pennsylvania. 2003. Last accessed: 1/25/2019.

<sup>9</sup>[Pennsylvania Medical Malpractice Filings, 2000-2017](#). Unified Judicial System of Pennsylvania, [Medical Malpractice Statistics website](#). Last updated 9/20/2018. Last accessed: 2/14/2019.



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There is no evidence suggesting that individuals obtaining care in any Pennsylvania county lack access to courts in which to file malpractice claims, nor is there evidence that counties where malpractice actions are currently being litigated are not rendering fair results. Many counties experienced increased filings after the 2002 reforms went into effect. Further, tenuous or frivolous claims were themselves a target of the 2002 reforms—e.g. the Certificate of Merit requirement—and can explain the overall drop in filings. Additionally, our members tell us that over the past decade or more, common practice now is to settle larger numbers of claims pre-litigation.

Moreover, the Patient Safety Authority, created at the time of the reforms, publishes statistics which should be addressed here. Our members point out that reporting of outcomes to the Authority goes far beyond medical error, and the number of true medical error incidents are far exceeded by the current court filings, so any reference to the Authority's overall statistics as proof of uncompensated harm from professional negligence is highly misleading. There is no Recommendation that the court venue rule be changed.

**Logic and Fairness Dictate that the Venue rules remain in medical liability matters.**

There are logical and ethical arguments for the current rule. Where negligence is alleged to occur, where witnesses are located, where health care professionals and the patient may reside; this ought to be the place where a trial occurs. Further, our state faced a medical liability insurance crisis of epic proportions only 16 years ago. Reforms, including this one, enacted at that time, should not be repealed simply because the crisis has abated and the reforms were successful. Such a move flies in the face of logic.

Conversely, trying a case in a distant jurisdiction which has no obvious connection to the matter is illogical and unfair. For one, it encourages forum shopping, the practice of picking the friendliest jurisdiction to large recoveries. On this point, some may argue the doctrine of forum non conveniens, or inconvenient forum, will eliminate the threat or temptation of forum shopping. This is not true. All such disputes over convenience, if this bright line venue rule does not continue, will need to be argued, briefly and fully litigated before a case can go forward, driving up costs. Furthermore, anyone who has handled such a dispute knows it is a high burden for a movant to prove the forum is inconvenient. Perhaps a health system in Allegheny County, where the alleged act occurred, could not be brought into court in Philadelphia, but there are cases holding that even hundreds of miles are not an inconvenience, let alone 50 or 100 miles.

**Finally, the proposal, if adopted, would represent a departure from the past practice of building consensus on rule changes that could have a significant public policy impact.**



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The Interbranch Commission on Venue, created under Act 13 of 2002, was comprised of appointments from the legislative, executive, and judicial branches of government. A majority of the members of the commission recommended that medical liability cases only be filed in the county in which the cause of action arises. The Pennsylvania Supreme Court adopted the commission's recommendation, as did the General Assembly through Act 127 of 2002. In short, the current venue policy was effectively built by three separate branches of government, while the current proposal to reverse that policy is a unilateral move that sets a dangerous precedent—one that may undermine future opportunities for interbranch collaboration.

For all of the reasons stated, HAP believes that the Supreme Court should not implement the proposed rule change. It also is worth noting that HAP has been joined by more than 20 health care provider and advocacy groups in opposing this change. A joint comment letter sent to the Supreme Court's Civil Procedural Rules Committee reflecting this opposition also is attached to the testimony, and incorporated by reference.

HAP appreciates the opportunity to provide comments to the Legislative Budget and Finance Committee, and we hope that the information we provided will assist you as you draft your report.

We are confident that your report will find that changes to the venue rule are not in the public interest, and would again lead to higher premiums for medical liability insurance, make Pennsylvania less attractive to physicians considering practicing in the state, increase medical costs, and adversely impact access to care for consumers.

Pennsylvania Medical Society  
Testimony to  
Legislative Budget and Finance Committee

June 25, 2019

Presented by:

Danae Powers, M.D.

President

Pennsylvania Medical Society



Good morning Chairman Mensch, Vice Chairman Brewster, and members of the Legislative Budget and Finance Committee. I am Dr. Danae Powers, President of the Pennsylvania Medical Society, a physician member organization of more than 23,000 physician members. I appreciate the opportunity to provide a physician's perspective on the proposed venue rule change and to be the voice of Pennsylvania physicians.

PAMED would like to extend our sincere thanks to Senate Judiciary Chair Lisa Baker and her Senate co-sponsors for introducing and advocating for Senate Resolution 20.

By way of background, I am a board-certified anesthesiologist serving rural Pennsylvania counties around State College. I completed my medical degree from Albany Medical College through a combined bio-medical program with Rensselaer Polytechnic Institute in Troy, NY. I have also worked for the University of Pittsburgh Medical Center liver transplant team as well as the University of Pittsburgh School of Medicine. While in Pittsburgh, I also worked for Allegheny General Hospital directing anesthesia research and teaching.

Because of this resolution, we have been afforded the opportunity to explain the potentially harmful impacts of this proposed change. What may seem like a procedural change, will in fact, impact the physician workforce and the 12.8 million Pennsylvanians we care for every day.

*We sincerely believe that patients who have suffered loss deserve their opportunity to be heard in a court. And, regardless of our perspective in this discussion, I know this to be true: we are all committed to protecting and promoting the health of Pennsylvania's citizens and ensuring fairness in the judicial system.*

The Pennsylvania Medical Society strongly opposes the proposal presented by the Civil Procedural Rules Committee. The proposal presented by the Committee threatens three distinct but inter-related issues: forum shopping in metropolitan markets across the Commonwealth, the stability of liability premiums for physicians to practice in the state, and perhaps most importantly, the impact on patients and their ability to access quality care.

***[Forum shopping/Venue shopping]***

First, the venue rule, which went into effect in 2003, was designed to address forum shopping—the proclivity of plaintiff's attorneys to file medical professional liability actions in high verdict counties, such as Philadelphia, even when there was no sensible connection between the county and the care received by the plaintiff.

Philadelphia is regularly used as an example of the potential abuse of venue.

- Between 2000-2002, Philadelphia County averaged 1,204 medical malpractice filings—44 percent of the cases filed statewide.

- From 2003-2017, after the venue restricts were put in place, the highest number of filings in Philadelphia was 586 filings—29 percent of the cases filed statewide.
- Since courts prohibited forum shopping in 2003, there was a 66.3% decline in medical liability cases filed in Philadelphia County.

One of my colleagues explained of a time in the early 2000s when he was involved in a lawsuit. He had only seen the patient as a referral, had done nothing wrong and had no direct, long-term involvement in the patient's care, but when the lawsuit was filed, he of course was part of it. The action was filed in Philadelphia, where the physician wasn't even from. His attorney and insurance carrier recommended settling the case based upon nothing except the fear of the Philadelphia court system and the fact that litigating the case in Philadelphia was going to be more costly than settling.

As I stated earlier, we sincerely believe that patients who have suffered loss deserve their opportunity to be heard in a court room. Physicians and other health care providers likewise deserve the opportunity to be able to defend themselves without the demonstrated bias of some jurisdictions.

Returning to a rule that permits medical professional liability suits in the county where the defendant regularly does business will mean that a physician will be required to defend a case possibly hundreds of miles away from where they work, robbing other patients of the care they would have otherwise been able to provide.

Thankfully, the certificate of merit and possibly other reforms have had positive effect. The number of cases filed, and physicians sued, declined significantly. While at the same time, both the plaintiff and defendant were given a fair opportunity to be heard in their local community, by local jurors and judges.

### ***[Liability Premiums]***

Second, the proposed changes could also usher the return of skyrocketing medical liability premiums for physicians that we saw and felt in the late 1990s and early 2000s. Even with our current reforms in place, medical liability insurance costs in Pennsylvania still rank near the highest in the nation. These proposed changes threaten to make that even worse.

The proposed rule would increase cost for the professional liability insurance carriers in the state and a domino effect could ensue:

- Medical liability carriers may voluntarily or involuntarily move out of the Pennsylvania market. Insurance carriers could become selective in who they choose to underwrite. This impacts all Pennsylvania physicians, as the number of carriers has the potential to decrease, making it increasingly difficult to find professional liability coverage in the state.
- Since professional liability insurance is required to practice in the state, physicians could be left with three options: seek other practice alternatives, retire, or leave the state all together, which Pennsylvania began to see in the early 2000s.

I have been told there is the feeling that this proposed change shouldn't bother physicians since most physicians are employed and therefore don't pay for their own medical liability insurance. Although it is true that more physicians are employed than in previous years; there are still significant numbers of physicians who continue to operate independently and do pay their own insurance and other costs.

These physicians often practice in medically underserved areas. Along with paying their own insurance, they are also employers supporting the local economy and community. Increases in these expenses means they must find cuts in their business operations, the same as any other business must do when faced with increasing costs and no increase in revenue.

This statement that physicians don't pay their own medical liability expenses also overlooks the fact that someone still pays these expenses. Whether it is a health care system or another entity, the ultimate cost must still be passed along to the consumer, in most cases the patients; either in higher out of pocket expenses, higher insurance premiums or both.

***[The impact on patients and their ability to access quality care/Rural Areas]***

Most importantly, the proposed venue rule changes could threaten patient access to quality physician care, particular in the state's rural areas:

- Forty-eight of Pennsylvania's 67 counties—home to more than 25 percent of the state's residents—are designated rural.
- Twenty-two percent of Pennsylvania's citizens live in areas with health care provider shortages.

The rural access to care problem links directly to and is exacerbated by the medical professional liability insurance issue.

A 2016 Pennsylvania Rural Health Association's report points out that affordable medical professional liability insurance is a major factor for physicians when contemplating where they will practice. And, although greatly improved from the early 2000's, Pennsylvania's liability climate continues to be a challenge, discouraging physicians from choosing to train or practice in Pennsylvania.

The difficulty of getting health care providers to locate in Pennsylvania's rural areas is well documented. If the current venue rule is changed, we will risk losing those providers who already live and work there and discourage others from choosing to care for patients in these areas.

Under the current rule, if sued for an alleged medical error, physicians who choose to practice in a rural area can expect to defend in his rural county, submitting to the liability and compensation judgments of the citizens of that county. If the venue reform is rolled back, however, it is more likely than not that the plaintiff will seek to sue in Philadelphia or some other jurisdiction with a record of high plaintiff success or verdicts. This means that the physician is away from their practice for a longer period of time, thus reducing patient visits during the legal proceedings and impacting a patient's ability to see their physician in a timely manner.

In addition to time away from patients, the rural physician will face a higher likelihood of plaintiff verdicts, a higher verdict or settlement amount, and a resulting higher MPL insurance rate and MCARE assessment.

***[Closing]***

I know that the liability crisis in the late 90's and early 2000's brought the Commonwealth's medical community to its knees as high-risk specialists like neurosurgeons curtailed complex surgeries, OB/GYN's stopped delivering babies, and the ability to recruit physicians to practice in the Commonwealth all but dried up. Vulnerable populations like older Pennsylvanians, newborns, expectant mothers, and trauma patients suffered while personal injury lawyers unfairly pocketed millions in contingency fees.

The current venue rule, which stipulates that medical liability claims must be filed in the county where the alleged medical error occurred, helped stabilize the medical liability climate back in 2003. And despite this, oddly enough, the Committee proposes to undo the very reform that helped create the stability by pointing to the significant reduction in medical professional liability actions over the past 15 years. To the contrary, a reversal of the venue rule will only serve as a catalyst for a resurgence in forum shopping for verdict counties like Philadelphia.

We must learn from history, or we are doomed to repeat it. The result of the proposed venue rule change by the Civil Procedural Rules Committee will create a domino effect of negative implications for the professional liability insurance market, physicians, other health care providers, and most importantly, access to quality care for all Pennsylvanians.

Thank you again for the opportunity to share with you my concerns regarding the proposed venue rule and I would be happy to address any questions you may have.

*Peter J. Hoffman, Esquire*  
215-851-8420  
*phoffman@eckertseamans.com*

February 20, 2019

**VIA ELECTRONIC MAIL**

Karla M. Shultz, Counsel  
Civil Procedural Rules Committee  
Supreme Court of Pennsylvania  
Pennsylvania Judicial Center  
PO Box 62635  
Harrisburg, PA 17106-2635  
civilrules@pacourts.us

Re: Proposed Venue Rule

Dear Ms. Shultz,

I am pleased to write concerning the proposed rule.

I was privileged to have served on the Rules Committee and honored to have been Chair. As a matter of background, I was involved in the discussions and drafting of Act 195 as well as Act 13 (Medical Care Availability and Reduction of Errors Act). I also served on the Pennsylvania Senate Select Committee on Medical Malpractice, as well as Governor Rendell's Task Force. I had been asked by Former Chief Justice Cappy to work with the Honorable Stanton Wettick and Gerald A. McHugh, Esquire (now Hon. Gerald McHugh of the Eastern District of Pennsylvania) to discuss and draft various reforms including certificates of merit and venue.

In full disclosure, I have been practicing in the Commonwealth for over 40 years. A significant portion of my practice has entailed defense of health care providers in professional liability cases.

I have set forth below a number of considerations with respect to the venue rules governing Pennsylvania medical malpractice actions. It should be noted that venue has no constitutional dimension, it is merely a matter of statutory grace. While it certainly implicates issues of fairness, the landscape for these issues has changed in Pennsylvania during the past two decades. The private insurance market is much different today than it was prior to the enactment of the current rule. The largest health systems have structured themselves differently, and have notably expanded their influence beyond the urban centers out into the more rural and suburban counties. Stakeholders in the system have achieved a certain balance based, in part, on a rule that proponents of the amendment have labeled "unfair." I understand their argument, but I do not think it holds water upon close examination.

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### MCARE – The Legal Landscape

The Medical Care Availability and Reduction of Errors (“MCARE”) Act was enacted in 2002 due to a healthcare crisis that was occurring in Pennsylvania. While there are those who labeled it a “non-crisis” which was “manufactured,” they are incorrect. It was a real crisis. I know since I lived through it. It was recognized as a crisis by the General Assembly, Governor Rendell’s Task Force and the Court.

Prior to 2002, Pennsylvania citizens were facing decreased access to care. There was a diversion of resources within healthcare systems due to rising medical professional liability costs. Physicians were leaving the state due to the inability to obtain professional liability coverage. Residents were not pursuing their profession in some of our leading hospitals. Healthcare providers in some cases were practicing defensive medicine to protect themselves against possible lawsuits. Hospitals, physicians, and nurses were reluctant to report quality concerns or participate in collaborative efforts to improve patient care out of fear the information would be used during litigation.

Additionally, physicians in Pennsylvania were facing difficulty in obtaining medical liability coverage. Any coverage that could be obtained came with drastically increased premiums compared to the national average. Prior to 2002, only two of the top insurers for physicians remained in the state. There were numerous carrier liquidations. As of 2002, on a per capita basis, the aggregate medical professional liability premiums incurred in Pennsylvania were the highest in the nation. Pennsylvania claim payments were also some of the highest in the nation and were increasing at a rate faster than the rest of the country. In Pennsylvania, the number of million dollar plus settlements of medical malpractice lawsuits increased by fifty percent between 1999 and 2001, and the median verdict in Philadelphia County was twice the state median.

In response to this healthcare crisis, the Pennsylvania legislature enacted the MCARE Act. Courts faced issues with respect to the cases being funneled to plaintiff-friendly jurisdictions. Insurance coverage became unaffordable. Rule 1006 was designed to prevent a collapse of the health care system. The MCARE Act provided comprehensive reform in hopes of providing more fundamental fairness to medical malpractice litigation. Notably, the General Assembly recognized the changing landscape of healthcare systems’ effect upon the existing venue rules. A joint task force on venue was formed, which favored the present venue rule. The Pennsylvania Supreme Court subsequently amended the applicable rules of civil procedure to impose a threshold certificate of merit requirement for each filing, and limited venue to the county in which the cause of action arose.

After more than fifteen years, the Civil Procedural Rules Committee of the Supreme Court has proposed rescission of the venue rule in medical malpractice cases. According to the proposal, “data compiled by the Supreme Court on case filings on medical professional liability actions indicates that there has been a significant reduction in those filings for the past 15

years...result[ing] in a decrease of the amount of claim payments [and] resulting in far fewer compensated victims of medical negligence.” With all due respect, this proposal, however, is misguided.

### What Do the Statistics Say?

The proponents for the amendment to Rule 1006 rely on incomplete data. On September 20, 2018, the Research & Statistics Department of the Judicial Administration Office of the Pennsylvania Courts published a Table tracing the number of Pennsylvania Medical Malpractice Filings since 2000 through 2017 (“Table 1”).<sup>1</sup> The Explanatory Comment in support of the amendment asserts that Table 1 evidences a “significant” reduction in medical professional liability filings for the past 15 years. While the overall number of medical malpractice filings may have decreased since 2003, Table 1 utilizes a condensed comparison group which, in turn, portrays a pronounced decrease in the number of medical malpractice filings. Those seeking to amend Rule 1006 are quick to attribute this statistical decrease to the doctrine of venue and where a plaintiff may file suit. To the contrary, the concept of venue does not *bar* a plaintiff’s ability to file a lawsuit, it is merely a guide on *where* a plaintiff may file his or her action.

The statistics relied upon in Table 1 do not tell the whole story of the situation prior to and following the enactment of Rule 1006. Specifically, Table 1 portrays 15 individual years of annual filings beginning in 2003, as compared to merely 3 years of average annual filings from 2000-2002. The three-year average for medical malpractice filings from 2000 through 2002 is hardly an accurate representation of the medical malpractice filings prior to 2003. Proponents of the amendment seek to have the Pennsylvania Legislature ignore the pre-2000 filing statistics in an effort to dramatize the number of medical malpractice cases filed since enacting Rule 1006.

In addition, the statistics relied upon by proponents of the amendment actually demonstrate a theme of distribution rather than decline. For example, medical malpractice filings in Philadelphia County decreased from 1,365 in 2002 to 577 in 2003. In neighboring Montgomery County, professional liability filings increased from 21 filings in 2002 to 102 filings in 2004. Similarly, in Bucks County, medical malpractice filings decreased from 44 in 2002 to 3 in 2003, then filings surged to 43 filings in 2004 and 62 filings in 2005. In Western Pennsylvania, although Butler County experienced a -84.0% change from its 2000-2002 average, the neighboring Lawrence County increased by +125.0% from its 2000-2002 average. Although the statistics portray a decrease in filings in some counties after 2003, other counties experienced a dramatic increase in the annual number of filings.

As we all know, statistics can be interpreted for a particular purpose and do not portray the total problem and are not a substitute for logic and common sense.

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<sup>1</sup> Table 1: Pennsylvania Medical Malpractice Filings (September 20, 2018), *available at* <http://www.pacourts.us/assets/files/setting-2929/file7458.pdf?cb=656af3>.

Finally, advocates seeking to rescind subdivision (a.1) cannot conclusively attribute the decrease to the enactment of Rule 1006(a.1). As discussed, the venue rule does not bar the plaintiff's ability to file a lawsuit. Proponents of the amendment ignore the enactment of Rule 1042.3, which required, for the first time, that a plaintiff file a certificate of merit along with the complaint. *See* Pa.R.C.P. 1042.3(a). The certificate of merit rule was enacted in January 2003, just prior to Rule 1006(a.1), to prohibit the filing of frivolous professional liability lawsuits. Rule 1042.3 acts as a clear bar to a plaintiff's ability to file suit. It is disingenuous to conclude that a decrease in medical malpractice filings is solely due to Rule 1006(a.1) without first distinguishing the number of cases that were not filed in response to Rule 1042.3, as well as other provisions in Act 13.

For these reasons, the statistical evidence in support of amending Rule 1006(a.1) is flawed by a restricted comparison group resulting in unreliable percentages. Moreover, the alleged decrease in medical malpractice filings since 2000 cannot be attributed to the enactment of Rule 1006(a.1) alone. Therefore, advocates seek to rescind Rule 1006(a.1) based on a hypothesis rather than fact.

#### Victim Compensation

Despite the position that compensation to victims has diminished since the enactment of the venue statute, publicly available information collected on LexisNexis reveals that the average reported jury award has likely increased slightly in medical malpractice cases in Pennsylvania from about \$3M to \$3.5M.

Furthermore, based on the information published by the Unified Judicial System of Pennsylvania, the percentage of large verdicts (>\$5M) has also increased. Thus, when a jury finds it appropriate to compensate a plaintiff today, the trend has been to award higher amounts than before the MCARE venue rule was enacted. Therefore, it cannot be said that there has been a decrease in payments to medical malpractice plaintiffs.

Proponents of the Amendment look only at verdicts. This fails to recognize the reality that around 90% of cases settle. These settlements are usually confidential, but there are many settlements involving Philadelphia County cases that are high seven figures or eight figures.

To say that there are fewer compensated victims today than after the rules were implemented is taken out of context. As previously mentioned, while the overall number of medical malpractice cases has decreased since 2000-2003, this ignores the pre-2000 data, during which time medical malpractice filings were also significantly lower.



Moreover, the venue rule proponents again fail to recognize the effect of the implementation of the certificate of merit requirement. With Rule 1042.3, for the first time, plaintiffs were unable to file suit absent a threshold certification by a licensed professional to support the viability of their complaint. To attribute decrease in compensation to victims from the venue rule alone, while turning a blind eye to the certificate of merit requirement, simply fails to appreciate the simultaneous significant change in pleading requirements. The idea that a repeal of Rule 1006(a.1) will allow otherwise uncompensated victims to be compensated is pure sophistry. If a plaintiff's attorney is unwilling to file a case in Lancaster County, but willing to file the same case in Philadelphia County, then the problem is not the rule, but the attorney.

Finally, to suggest that plaintiffs cannot fairly be compensated in the jurisdiction where the claim arose implies that courts that currently hear medical malpractice cases are unable to provide an adequate judicial forum. This is to say that it is inherently unfair for a court to hear a case if the conduct at issue occurred in that venue. This suggests that the judicial system in that particular county is unable to adhere to the central protections afforded by the Pennsylvania Constitution and a myriad of court rules meant to protect the fundamental right to a fair trial. In fact, there have been many large eight figure verdicts in suburban Pennsylvania counties.

Medical malpractice plaintiffs were never stripped of a forum in which they may assert their claims. Indeed, they are permitted to bring the action in the county where the care at issue took place, which is quite likely the same venue in which they live, and where all essential evidence and witnesses may be found. Accordingly, plaintiffs have never lost any right or ability to fully recover in the event that liability is imposed by a jury of their peers. The present venue rule, therefore, makes the most sense for the convenience of plaintiff and the defendants.

### Potential Effects of the Proposed Amendments

#### *Patient Access to Quality Care*

The proposed amendment has the potential to significantly impact both access and quality of care for patients. This should be the issue that this Committee spends the most time studying rather than the "statistics." If there is a primary goal of increasing patient access to quality care, then one must ask whether repealing Rule 1006(a.1) is consistent with that goal. I say it is not consistent. Repealing Rule 1006(a.1) will act as a disincentive for large, well organized, quality health care systems from investing resources in counties outside Philadelphia and Pittsburgh. It adds a layer of risk and will disrupt the balance of business decisions about whether to purchase and invest in rural facilities. Patients benefit when a large health system invests resources in rural counties. Patients have better access to care and the quality of care is increased. If this Committee is concerned about patient access to quality care, it must pause and consider the consequences of repealing the current venue statute.

Those who support repeal of Rule 1006(a.1) ask why should hospitals be treated differently than other defendants. The answer is quite simple. A hospital is not like a widget manufacturer. A hospital's job is to provide medical care. When a hospital decides to do business in a certain region, it makes a commitment to the health of the community there. This is fundamentally different than the decision made by a purely for-profit corporation that decides to sell products in a new territory. Accordingly, when some difficulty arises in the provision of these services, it does not necessarily make sense to allow the hospital system to be sued in all jurisdictions where it does business. Indeed, it makes more sense to limit jurisdiction to the place where the care took place. Hospitals have a unique obligation to the communities they serve, and each county court system is more than capable of handling the lawsuits that arise from the care rendered inside its borders.

### *Judicial Resources and Litigation Expense*

Importantly, there has been no investigation into the effect this proposed change will have upon judicial resources. If the proposed amendments are enacted, the new rule will invite forum shopping, and it is undeniable that the majority of medical malpractice lawsuits will be filed in plaintiff-friendly venues. At this point, it is unclear if the courts in counties that will receive an influx in filings will have the resources to handle such a dramatic increase.

Typically, in Philadelphia for example, a professional liability matter will be given a trial date two years after the date of filing. There has been no investigation into the effect that this proposed rule change will have upon this current timeline. However, there will undoubtedly be a decrease in filings in different Pennsylvania counties, which currently do have the judicial resources necessary to hear medical malpractice cases in a timely manner.

Along with an increase in filings, there will be a significant increase in motion practice. There will be a rise in the filing of preliminary objections, discovery motions, and motions to transfer for *forum non conveniens*. These motions will require time and judicial resources to reach disposition, and will unnecessarily increase the cost of litigation for both plaintiffs and defendants.

One might suspect that the ability of a Plaintiff Lawyer to “steer more cases to plaintiff-friendly courts”<sup>2</sup> is the primary reason driving repeal of this rule. It pales in comparison to considerations regarding patient access to quality healthcare, and it shows a sharp conflict of interest between proponents of the amendment and the patients they may seek to represent. The incremental benefit of repeal that inures to a rural victim of medical negligence does not outweigh the disadvantage conferred on all rural patients who may no longer have access to quality care.

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<sup>2</sup> Matthew Santoni, *Pa. Senate Wants Time to Study Looser Med Mal Venue Rules*, LAW360, Feb. 5, 2019, available at [https://www.law360.com/personal-injury-medical-malpractice/articles/1126000/pa-senate-wants-time-to-study-looser-med-mal-venue-rules?nl\\_pk=a26eb4da-7aa3-41a2-9f4e-3ca97dd4895a&utm\\_source=newsletter&utm\\_medium=email&utm\\_campaign=personal-injury-medical-malpractice](https://www.law360.com/personal-injury-medical-malpractice/articles/1126000/pa-senate-wants-time-to-study-looser-med-mal-venue-rules?nl_pk=a26eb4da-7aa3-41a2-9f4e-3ca97dd4895a&utm_source=newsletter&utm_medium=email&utm_campaign=personal-injury-medical-malpractice) (last visited 2/7/19).

In sum, there should be no urgency to repeal a rule that in many ways, solved a crisis. The Committee's Explanatory Comment in support of repeal relies on conjecture, and unconvincing appeals to "fairness." The rules on venue and certificates of merit as well as reforms contained in the MCARE Act, were instituted in dealing with a real crisis. It makes no logical sense to repeal the venue rules. If a physician prescribes treatment to deal with a medical problem, would it make sense to stop treatment? The answer is obvious. Repeal of this rule will undoubtedly have wide-ranging impacts that have not been studied or considered by this Committee. At a minimum, the Committee should delay ruling on the proposed amendments so it can analyze whether a legitimate basis exists for repeal, as well as the probable consequences and impacts that would result from repeal.

This position is consistent with Pennsylvania Senate Resolution 20, which reasonably asks that the Legislative Budget and Finance Committee hold at least one public hearing, and be given until January 1, 2020 to provide the General Assembly with a report studying the impact of the current proposal. As set forth in Senate Resolution 20, this ten-month delay "will give the legal community, the medical community, the business community, and the public ample opportunity to weigh in with the statistics, trends, arguments, and philosophies."<sup>3</sup>

Thank you for your consideration.

Respectfully submitted,



PETER J. HOFFMAN, ESQ.  
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Kevin F. Farrington, Esq.  
Alexandra D. Rogin, Esq.

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<sup>3</sup> Pa. S.R. 20, Regular Session 2019-2020 (2019), available at <https://www.legis.state.pa.us/cfdocs/Legis/CSM/showMemoPublic.cfm?chamber=S&SPick=20190&cosponId=28159>.

Senators Mensch & Brewster  
Chairmen – Legislative Budget and Finance Committee  
Room 400A, Finance Building  
613 North Street  
Harrisburg, PA 17105

*Re: Written Testimony, Senate Resolution 20 Hearing*

This written testimony is being provided on behalf of the Pennsylvania Association for Justice (“PAJ”), a non-profit organization comprised of 2,000 members of the trial bar of the Commonwealth of Pennsylvania. For over 50 years, PAJ has promoted the rights of Pennsylvanians by advocating for the unfettered right to trial by jury, full and just compensation for victims of negligence, and the maintenance of a free and independent judiciary.

PAJ supports the Civil Procedural Rules Committee’s proposed amendments to the Rules of Civil Procedure relating to venue as they remedy an inequity that should not have been placed upon victims of medical malpractice in this Commonwealth in the first place.<sup>1</sup> No rule should give one group of individuals or corporations special treatment and a preferred status. The preferred status given to malpractice defendants through the existing special venue rule must immediately be re-evaluated in light of data showing that the number of malpractice cases being filed has declined by 50 percent, while at the same time the number of medical errors has risen to a point where it is now the third leading cause of death in the United States.<sup>2</sup>

As the Explanatory Comment from the Rules Committee accurately notes, “[t]he current rule provides special treatment of a particular class of defendants, which no longer appears warranted.” This special treatment discussed by the Committee undermines fundamental notions of fairness and justice. The purpose of the Rules of Civil Procedure should be to ensure that all litigants – whether plaintiff or defendant; patient or doctor; individual citizen or billion-dollar corporation – have the same access to and rights before the courts of this Commonwealth. To date, health care providers and related entities enjoy a venue rule more limited than any other non-governmental entity in our Commonwealth. This special treatment not only contravenes notions of fairness and equality, but lacks justification.

As members of this Committee are aware, circa 2000, there were significant lobbying efforts made by various special interest groups to enact wide-ranging “tort reform” measures to combat an alleged medical malpractice insurance “crisis.” Without regard to the validity of the “crisis,” various legislative and judicial reforms were enacted, including passage of the Medical Care and Reduction of Errors Act (hereinafter “MCARE Act”).<sup>3</sup> Other enactments included the reduction in the amount of coverage

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<sup>1</sup> See, amendments to Pa.R.C.P. Nos. 1006, 2130, 2156, and 2179.

<sup>2</sup> Discussed further, *infra*.

<sup>3</sup> 40 P.S. § 1303.101—§ 1303.910

required by physicians from 1.2 million to 1 million dollars; the elimination of the collateral source rule; abrogation of joint liability; reduction to present worth for future earnings losses; and periodic payments of future medical and personal care expenses that are extinguished upon death of the malpractice victim. Proponents of “tort reform” (hospitals and insurers) achieved their goals - these changes, by design, significantly reduced the financial exposure of malpractice defendants and decreased access to the courts.

Additionally, in 2003, the Rules of Civil Procedure were modified quite extensively to (1) place limitations on the plaintiff’s choice of venue by requiring that medical malpractice cases be filed in the county where the alleged malpractice arose, and (2) require medical malpractice cases be filed with a Certificate of Merit from a physician stating that there is a reasonable probability that a medical malpractice defendant deviated from the accepted standard of medical care, which caused the plaintiff harm.<sup>4</sup>

While the Certificate of Merit requirement is applicable to all professional negligence claims – including those against accountants, architects, engineers, and attorneys – the current preferential venue rule only applies to health care professionals. There was not then, nor is there today, data that exists to connect the number of medical malpractice cases with venue restrictions. Because the current venue rule being reviewed through SR 20 was enacted as one small part of greater medical malpractice reforms, it is impossible, despite what will be said by those who wish to perpetuate the unfair rule, to point to the impact of venue limitations in isolation.

We know this for certain – claims used to manufacture the “crisis” that led to all of these changes were unsupported, if not nefariously fabricated. Doctors were not leaving Pennsylvania in droves “because they could not afford their malpractice insurance any longer.” Data shows that doctors were not leaving, but in fact they were gaining in numbers. “Despite claims that Pennsylvania is losing doctors to other states as a result of high liability insurance premiums, official statistics from the American Medical Association and from the Federation of State Licensing Boards show an actual per capita increase in treating physicians.” It should also be noted that supporters conveniently leave out the fact that all but one state contiguous to Pennsylvania has the same venue rule as the one currently being proposed by the Rules Committee.<sup>5</sup> And insurance rates were increasing because of market forces, not lawsuits.<sup>6</sup>

In addition to preventing the exodus of doctors (which was not true) and stabilizing insurance rates caused by malpractice lawsuits (also not true), “tort reform” was also supposed to make Pennsylvanians safer.<sup>7</sup> Unfortunately, that has not happened either. The citizens of Pennsylvania, like the balance of

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<sup>4</sup> See, Pa.R.C.P. Nos. 1006, 2130, 2156, and 2179 for “Venue Rule.” See, Pa. R.C.P. No. 1042.3. for “Certificate of Merit.”

<sup>5</sup> Delaware, New York, New Jersey, Ohio, and West Virginia all provide venue for malpractice actions in the county where the Defendant resides or conducts business. The only state contiguous to Pennsylvania that prohibits venue where the Defendant conducts business is Maryland. Note: In W.V. actions against nursing homes may only be filed where the Nursing Home in question is located.

<sup>6</sup> Steve Esack, *Politics, money and fears in Pennsylvania medical malpractice fight*, The Morning Call (Feb. 10, 2019), <http://www.mcall.com/news/pennsylvania/mc-nws-medical-malpractice-court-change-fight-20190204-story.html>. “For years, insurance companies set malpractice rates artificially low to gain customers. That practice caused three major malpractice insurance companies to go belly up in the 1990s and early 2000s. then, following a 2001 stock market swoon, insurers raised rates to offset investment losses.”

<sup>7</sup> The MCARE Act provides that “[e]very effort must be made to reduce and eliminate medical errors by identifying problems and implementing solutions that promote patient safety. See, 40 P.S. § 1303.102(5).

this country, face an epidemic. As the internationally renowned team of researchers at Johns Hopkins University School of Medicine recently concluded, preventable medical error is the third leading cause of death in the United States.<sup>8</sup> In Pennsylvania, the Patient Safety Authority statistics reveal that health care facilities, which do not include physician offices, reported 7,881 “serious events” in 2017.<sup>9</sup> These statistics demonstrate that our Commonwealth faces a much greater threat from preventable medical error than malpractice lawsuits.

Lawsuits effectuate positive outcomes by identifying problems and promoting patient safety. As a result of this “tort reform”, we are doing less about this problem than we ever have. The most recent data from the Supreme Court shows an almost 50 percent decrease in medical malpractice filings since 2000-2002.<sup>10</sup> In fact, 2017 saw the fewest medical malpractice filings (1,449) in more than fifteen years despite the nearly 8,000 “serious events” reported to the Patient Safety Authority. According to the United States Centers for Disease Control and Prevention, approximately 84 percent of adults and 92 percent of children have contact with a health care professional each year.<sup>11</sup> Despite how often Pennsylvanians come into contact with health care providers, and how often “serious events” (at least the ones that are actually reported) occur, only one person in 8,833 files a medical malpractice lawsuit.<sup>12</sup> This information shows that, sadly, we have far too much medical malpractice, and far too little justice for those who are injured or killed. When this Committee considers these facts in addition to the lack of any data confirming the impact of the special health care venue rule, it is clear that no legitimate reason exists to maintain this special privilege.

As stated by the Civil Procedural Rules Committee, the venue restriction rule and other rules are resulting in “far fewer compensated victims of medical negligence.”<sup>13</sup> Additionally, despite the requirement that all filed cases must be supported with a certificate of merit, thereby indicating that there is a meritorious claim, medical malpractice verdicts in Pennsylvania overwhelmingly favor defendants.<sup>14</sup> This trend is especially concerning in light of a national study published in the *New England Journal of Medicine* concluding that “[a]lthough the number of claims without merit that resulted in compensation was fairly small, the converse form of inaccuracy – claims associated with error and injury that did not result in compensation – was substantially more common. One in six claims involved errors and received no payment.”<sup>15</sup>

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<sup>8</sup> Martin A. Makary and Daniel Michael, *Medical error - the third leading cause of death in the US*, 353 *BMJ* 2139 (2016).

<sup>9</sup> A “serious event” is an adverse event resulting in patient harm. An “adverse event” is an event that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient. Patient Safety Authority, Annual Report, 2017 ([www.patientsafetyauthority.org](http://www.patientsafetyauthority.org)).

<sup>10</sup> Pennsylvania Medical Malpractice Filings Statewide 2000-2003 Avg. to 2017, available at <http://www.pacourts.us/assets/files/setting-2929/file-7458.pdf?cb=656af3>.

<sup>11</sup> Centers for Disease Control and Prevention, Summary Health Statistics: National health Interview Survey, 2018, available at [https://ftp.cdc.gov/pub/Health\\_Statistics/NCHS/NHIS/SHS/2016\\_SHS\\_Table\\_A-18.pdf](https://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2016_SHS_Table_A-18.pdf)

<sup>12</sup> 12.8 million Pennsylvanians divided by 1,449 malpractice filings equals 8,833.

<sup>13</sup> See, Pa. Civil Procedural Rules Committee, *Notice of Proposed Rule Making (Proposed Amendment of Pa.R.C.P. Nos. 1006, 2130, 2156, and 2179)*, Exploratory Comment.

<sup>14</sup> See Medical Malpractice Jury Verdicts: January 2016 to December 2016, The Unified Judicial System of Pennsylvania, prepared August 30, 2017, available at <http://www.pacourts.us/assets/files/setting-771/file-6329.pdf?cb=8929e6> (finding that nearly 80% of verdicts were in favor of the defense in 2017). Even in Philadelphia nearly 62% of the cases tried were defense verdicts and not one verdict in 2017 was over \$5,000,000.

<sup>15</sup> See David M. Studdert, et al., Claims, errors, and compensation payments in medical malpractice litigation, *N. Engl. J. Med.* 2006; 354, 2024-33 (May 2006)

The cumulative effect of the nearly dozen “tort reform” measures that were adopted seventeen years ago is that 50 percent fewer Pennsylvanians have been able to access justice. This decrease in access to our courts is not cause for celebration, especially when juxtaposed against the terrifying fact that medical errors are occurring at an alarmingly high and steadily increasing rate.

The Pa. Supreme Court’s 2003 enactment of the special venue rule for medical malpractice defendants as well as several other procedural and substantive law changes at that time have reduced the number of lawsuits in the commonwealth. It may not be possible to measure and know exactly how much any one change has contributed to this outcome. However, what can be measured and is known is that profits motivate those who wish to perpetuate the special venue rule. The rules of civil procedure are not designed to benefit any one party in such a fashion. It is axiomatic that the rules are designed to promote equality and fairness of process; the rules should be agnostic as to outcome.

Supporters of the special venue rule have resorted to their usual fear-mongering sound bites – “doctors will flee,” “insurance premiums will increase,” and “hospitals will close.” Each of those claims, as stated above, have been proven untrue, thus the “favoritism rule” for doctors and hospitals is no longer needed. Moreover, hospitals like UPMC, UPenn, and Geisinger are more profitable than ever – even if they purport to be non-profit entities. Not to mention that patient safety (which is the most important issue) has not improved and, in fact, has gotten worse since the enactment of “special treatment” to doctor and hospitals. All of these facts warrant elimination of the special status venue rule for hospitals.

Furthermore, the healthcare delivery model has changed markedly since the early 2000s. Conglomerate hospitals and the health insurers are taking control of all the health care and health insurance in every county in Pennsylvania, not just the county where they are headquartered. They are dictating staffing, safety rules, coverage issues, etc. to the local community hospitals they own. As such, they should be able to be sued in the places where these decisions are made, not the county where the victim of malpractice was injured or dies. By abrogating the special venue rule, equality and fairness will be restored to the civil justice system, allowing conglomerate hospitals and insurers to be held accountable for unnecessarily injuring or killing so many Pennsylvanians.

Sadly, the only change being discussed is the special venue rule and not the numerous other procedural and substantive changes that were implemented in the early 2000s. All those other “tort reform” initiatives, similar to venue, have since proven to be nothing more than profit schemes that have systematically contributed to the erosion of patient safety.

The Rules Committee stated, “the special treatment [afforded to malpractice defendants] no longer appears to be warranted.” In reality, it was never warranted in the first place, because there was never any actual statistical support for the change, and it most certainly is not warranted now given the rise in medical errors in an age where the healthcare delivery system has now placed patient safety in the rearview mirror.

# Barley Snyder

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June 21, 2019

VIA EMAIL: [clatta@palbfc.us](mailto:clatta@palbfc.us)

Christopher Latta, Deputy Executive Director  
Legislative Budget and Finance Committee  
P.O. Box 8737  
Harrisburg, PA 17105-8737

**Re: Venue Rule Testimony of Katherine B. Kravitz (PBA)**

Dear Mr. Latta:

Enclosed please find my venue rule testimony which I will be presenting on June 25, 2019 at 11:00 a.m. before the Budget & Finance Committee.

Very truly yours,



Katherine B. Kravitz

KBK:kag  
Enclosure



## **Testimony re: SR20 before the Legislative Budget & Finance Committee**

**Katherine B. Kravitz  
Barley Snyder  
Lancaster, PA  
June 25, 2019**

Thank you for the opportunity to offer testimony before the committee today.

I would like to start by taking you back to 2000; that year, Measles was declared to be eradicated in this country, thanks to a highly effective vaccination program. So why then, have we seen more than double the measles cases in the first six months of this year than there were in all of last year? Before you say Mrs. Kravitz, you are in the wrong hearing, let's answer the question, because what happened was at least in part due to the fact that pockets of people throughout the country decided that the vaccination that had kept the problem at bay all these years, was no longer needed. That is where that problem and this one intersect, because it truly defies logic to consider doing away with a tried and true prophylaxis when the problem it was designed to prevent would very likely reoccur.

Given the relative stability the professional liability insurance market has experienced in the last 15 years, it would be easy to forget just about the problem in question. So let's review:

- Premiums for Pennsylvania physicians in the essential areas of internal medicine, general surgery, and obstetrics/gynecology increased by 100% or more between 2000 and 2002; premiums for orthopedists in Pennsylvania were some of the most expensive in the country;
- Pennsylvania hospitals had among the worst insurance availability problems in the nation;
- A glut of cases were filed in Philadelphia County, overburdening that counties system and forcing health care providers to litigate in foreign venues;
- Several of the major liability insurance providers, including PHICO, PIC and MIIX, went belly up, leaving behind underfunded claims, gaps in insurance, health care providers personally exposed to liability;
- Emergency rooms, labor and delivery units and entire hospitals closed their doors, severing community access to care.

That situation was not good for patients, for plaintiffs or for health care providers. In reality, hospital closures continue to be a problem, particularly in rural America. In order to survive, and in attempt to provide the best service possible to their communities, many hospitals of various sizes and capacities, have integrated with regional health systems based in larger venues like Philadelphia and Pittsburgh. Our legislature demonstrated keen insight into the future of health

care when it acknowledged in prior legislation, the detrimental impact forum shopping would have on providers from smaller communities if, for example, they could be dragged into Philadelphia for litigation simply because Philadelphia was the home base of a system they joined. In fact, one of the arguments I have heard from Plaintiff attorneys in support of revoking the venue rule is that ‘those big systems knew what they were getting into’ and, ‘they did it for money.’ I do not think that bringing a community hospital into the fold is necessarily a big cash cow for health systems. Indeed, revocation of the venue rule would more likely discourage what might be hospital saving affiliations, because the potential to be sued in Philly or Allegheny would add another layer of potential liability for *all* involved.

However, regardless of the economics of healthcare integration, dragging the Dauphin County provider into Pittsburgh or forcing the Lancaster county provider to litigate in Philadelphia punishes the Dauphin county hospital, the Lancaster County doctors more than the Health System itself. Frankly, no health care provider should be punished for looking for ways to provide better and more healthcare service to more people, and that is what you do if you take away the venue rule.

Another argument that has been proffered in support of revoking this preventative measure is the suggestion that would-be plaintiffs are going uncompensated because of it. While no objective data has been provided in support of this assertion, the Plaintiffs Bar seems to point to the overall reduction in medical malpractice claims being filed, and the fact that there are counties in the Commonwealth where Plaintiff’s verdicts in a medical malpractice case are rare. In response to such claims, consider the following:

- The venue rule was *meant* to reduce the number of claims brought inappropriately in Philadelphia County. This goal has been accomplished as evidenced by the fact that while Philadelphia County has seen a robust decline in cases, Bedford, Bucks, Crawford, Greene, Indiana, Lancaster, Lawrence, Luzerne, Montgomery, Washington and Wayne Counties all have experienced *increases* in the average number of claims filed. My home county of Lancaster has seen an increase of over 270%.
- In addition, although loopholes to the Certificate of Merit Rule have in recent years detracted from their effectiveness, that aspect of the MCARE Act has undoubtedly also reduced the number of claims brought by weeding out those that cannot be supported by a qualified expert.
- The contention that Plaintiffs are not being compensated as evidenced by the lack of verdicts in some more conservative counties completely ignores the fact that many many more claims are resolved through settlement than are litigated in the courts. In its 2018 Report, the MCARE Fund reported that 1700 claims had been resolved through Alternative Dispute Resolution of one kind or another since 2003, and that is only the cases that reached the fund layer; many other cases that do not reach the Fund’s coverage are also resolved through settlement, with or without ADR.
- In 2018, the Fund and Primary Insurers paid out \$777 Million to Medical Malpractice Plaintiffs, which again, represents only a part of the overall payouts for all claims. Still, this number alone reflects a 30% increase in payouts for both the Fund and Primary Insurers over the last 5 years. While many factors affect these numbers, it is difficult to argue that Plaintiffs are going uncompensated in the face of such statistics. Indeed, one

prominent Philadelphia Plaintiffs firm has famously advertised the \$400 Million it recovered for clients in one recent year. I do not think that advertisement was born of a sense that either the firm or its clients had been short shrifted by a having to actually litigate their cases in the county where the events at issue occurred.

- An analysis performed by Diedrich Healthcare on 2018 medical malpractice payouts shows that Pennsylvania was ranked second in the country in total payouts and fifth in payments per capita. There is no reason, therefore, to believe that fewer victims of medical negligence are being compensated, or that revoking the venue rules would solve this imagined problem.
- Finally, many counties, Lancaster included, are beginning to see verdicts in Medical Malpractice cases. Don't tell Joe Roda or April Kutay that you cannot win in Lancaster, because they have both had seven figure verdicts in Lancaster within the last 5 years or so.

Plaintiff attorneys may also point to Forum Non Conveniens rules as being the proper remedy for addressing an inappropriate choice of forum. However, these attorneys know very well that the burden of proof for such a motion is terribly high. Furthermore, pursuing such motions are very labor intensive, sometimes involving Depositions and other Discovery just to resolve that issue. Medical Malpractice litigation is already costly and protracted enough without adding that additional burden.

It has been suggested that it is appropriate to bring cases in Philadelphia because the juries there 'get it right' while many other counties just do not fulfill their duties. This argument is an unacceptable affront to the men and women who give up their time to serve on juries, and swear or affirm to uphold the law in doing so. Because jurors in one county may be more conservative than jurors in another is certainly not a reason to artificially herd all cases in to Philadelphia.

Another common refrain among Plaintiff attorneys who support returning to the detrimental way of old is 'Why should Medical Malpractice cases be treated any differently than any other cases when it comes to venue?' To begin with, a hospital which is a part of a healthcare system based in say, Philadelphia is not like a McDonald's franchise. Rather, hospitals maintain autonomy, with separate governing boards, separate medical staffs, and separate licenses. The hospital remains entrenched in and committed to its own mission in its home community. Another reason to continue employing this appropriate preventative measure is the fact that health care is not an optional commodity; generally, most people will at some point in their lives be required to seek medical care. This underscores the need to ensure that all people retain access to care. Keeping the professional liability insurance market stable, and making Pennsylvania a welcoming place for new providers is essential to creating and maintaining that access to care. The venue rule is, by the way, not an unprecedented tweak to the general rules in recognition of a particular need. For example, in the 60's Pennsylvania legislators passed the Mental Health Procedures Act, which granted qualified immunity to behavioral health providers, as a part of the Act's overarching goal of assuring "the availability of adequate treatment to persons who are mentally ill[.]" See 50 P.S. §7102 (Statement of Policy).

In summary, it is of key importance that all citizens of the Commonwealth continue to have access to high quality, comprehensive health care. The venue rule helps achieve that, and there is

no evidence that anyone has been harmed by it. Rather, after the rule was enacted, filings went down in Philly and up in other places, because they were now being brought in the right place. Cases are still brought, cases are still fully and fairly litigated. Many are still resolved fairly through ADR. The venue rule is also not a crazy, illogical rule; it is not burdensome to comply with the rule. As a litigator, when I talk to juries at the end of a case, I am invariably asking them to put the evidence onto those scales of justice, and see which way the scales tip. Here, if you do that, the scales tip overwhelmingly in support of maintaining the venue rule as is; it is a tried and true preventative measure which has succeeded in solving a destructive, harmful problem. Even though the problem is not a “disease” per se, like measles, discontinuing administration of the venue rule’s good medicine is simply a bad idea on many levels.

Thank you.

June 21, 2019

Senators Mensch & Brewster  
Chairmen – Legislative Budget and Finance Committee  
Room 400A, Finance Building  
613 North Street  
Harrisburg, PA 17105

**Re: Written Testimony, Senate Resolution 20 Hearing**

Dear Senators Mensch and Brewer:

I am a lawyer from Western Pennsylvania (Erie) who primarily represents plaintiffs in personal injury and medical malpractice litigation. I submit this written testimony as one of two representatives of the Pennsylvania Bar Association (“PBA”). The PBA has not taken a position on the proposed amendments to the Rules of Civil Procedure relating to venue. PBA desires to present the different perspectives of the plaintiff and defense bars for the benefit of the Committee.

**History and Context of Venue Rules**

Prior to 2003, Pennsylvania’s venue rules (the rules that dictate where a lawsuit may be filed) were the same for all Pennsylvania people and businesses. Specifically, a plaintiff could commence a lawsuit where the incident giving rise to the lawsuit occurred, where the defendant resides or where the defendant (if a business entity) regularly conducts business.

Prior to 2003 and continuing through today, Pennsylvania’s venue rules allow a defendant to contest the plaintiff’s choice of venue and require a court to mandate a change in venue should it be determined that the plaintiff’s venue choice was improper. For example, when the plaintiff’s chosen venue is inconvenient for the parties or witnesses, the court may transfer the lawsuit to a different and more appropriate venue so long as the alternate venue otherwise meets the minimum venue requirements. Similarly, should the plaintiff’s choice of venue be found to be “vexatious and oppressive” or “designed to harass the defendant” the court may direct the lawsuit be transferred to a different and more appropriate venue.

The principle that venue is appropriate in either the county where the case arose or the county where the defendant resides or does business is not only well established in Pennsylvania law but is the prevailing rule in most other American jurisdictions. This well-established rule exists for good reason.

Pennsylvania courts are inherently fair. Our courts are not corrupt or biased. Our juries, absent circumstances that implicate self-interest, do not come to the courthouse with a vested interest in the outcome of a trial. Rather, fair proceedings are the rule and choice of venue is, far more often than not, a matter of convenience and efficiency.

Because Pennsylvania's courts are not corrupt, the only credible complaints about our venue rules are already addressed by the exceptions that allow courts, on a case-by-case basis, to change venue for reasons of convenience or to avoid the advancement of improper goals. In this regard, corporations who are required to defend themselves in a venue where they have voluntarily chosen to do business cannot, as a general proposition, plausibly articulate that they are inconvenienced by that venue.

Despite the inherent fairness of our courts, there may nevertheless be good reason in some cases for individual plaintiffs to view with skepticism the real or perceived self-interest of jury pools in small counties. In small communities, large corporations can exercise considerable influence, either as an employer of or customer/vendor to large percentages of the populace. Thus, the plaintiff in a small county who seeks justice against the region's largest employer faces considerable hurdles in finding jurors who are not, directly or otherwise, aligned with or dependent on the defendant. Having an alternative choice, a venue where the defendant has chosen to do business but is not as economically dominant, offers an increased likelihood of both actual and perceived impartiality while exacting no cost of inconvenience to the defendant.

In 2003, the Pennsylvania Supreme Court adopted changes to Pennsylvania's venue rules that required special treatment for medical malpractice defendants. After these changes, medical malpractice defendants stood apart from all other Pennsylvanians as the only defendants who could be sued only in the county where the cause of action arose.

At approximately the same time as the change in venue rules, other legislative and judicial reforms were enacted. The goals of these other reforms included the limitation of compensation to victims of medical negligence and reduction in the number of malpractice lawsuits. These reforms included reductions in the amount of insurance coverage required of physicians; the elimination of the collateral source rule; reduction to present worth for future lost earnings; periodic payments of future medical and personal care expenses terminable on death of the victim; and the requirement of a "Certificate of Merit" from a physician attesting to both negligence and harm.

At the time, lobbying groups working to effect these reforms claimed that medical malpractice lawsuits and payouts were causing a reduction in insurance offerings and increases in insurance premiums for policies that were offered. These groups claimed that physicians were retiring early or leaving Pennsylvania as a result and that Pennsylvania was at risk of being under-served by health care professionals.

In fact, medical malpractice insurance premiums were rising because of faulty pricing and insurance company investment losses, not because of indemnity payouts. More to the point, and despite the rise in insurance costs, physicians were not leaving Pennsylvania.<sup>1</sup>

Since 2003, medical malpractice lawsuits have decreased by 47% statewide, averaging 1,540 new lawsuits every year over the last 10 years.<sup>2</sup> Meanwhile, Patient Safety Authority data reveals that health care facilities, not including doctor’s offices, reported 7,881 events of patient harm caused by medical error.<sup>3</sup> Clearly, there is more medical malpractice than there are medical malpractice lawsuits.

Despite the prevalence of medical malpractice, verdicts in Pennsylvania have skewed dramatically in favor the defense. In 2017, defendants won 79.4% of all malpractice trials; in 2016, 84.5%; in 2015, 78.4%; in 2014, 82%; and so on. In no year since 2000, when data on Pennsylvania medical malpractice verdicts first was available, did plaintiffs win more than 30% of all trials.<sup>4</sup> These trial results do not suggest that the tried cases were examples of weak claims. On the contrary, a study of over 20 years of malpractice verdicts found that defendants won 80 to 90% of jury trials with weak evidence of medical negligence, 70% of borderline cases and, astoundingly, 50% of trials with strong evidence of medical negligence.<sup>5</sup> The New England Journal of Medicine confirms, “(A)lthough the number of claims without merit that resulted in compensation was fairly small, the converse form of inaccuracy — claims associated with error and injury that did not result in compensation — was substantially more common.”<sup>6</sup> Health care providers are winning trials they should lose at an alarming rate.

## **Pennsylvania Should Not Have Preferential Venue Rules for Medical Malpractice Defendants**

### **A. Fundamental Fairness**

It is axiomatic that the law should apply equally to all Pennsylvanians. Providing special privileges for people and corporations engaged in health care and no one else undermines faith in the impartiality of our laws. Compounding the inequity of this special treatment is that it only applies one way. That is, a hospital may sue to protect its own interests in any venue where the defendant resides or does business but, when an injured victim sues a hospital for malpractice, the victim is limited to the venue of the hospital’s choosing.

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<sup>1</sup> <http://www.mcall.com/news/nationworld/pennsylvania/mc-nws-medical-malpractice-court-change-fight-20190204-story.html>

<sup>2</sup> <http://www.pacourts.us/news-and-statistics/research-and-statistics/medical-malpractice-statistics>

<sup>3</sup> See, [http://patientsafety.pa.gov/PatientSafetyAuthority/Documents/annual\\_report\\_2017.pdf](http://patientsafety.pa.gov/PatientSafetyAuthority/Documents/annual_report_2017.pdf)

<sup>4</sup> <http://www.pacourts.us/news-and-statistics/research-and-statistics/medical-malpractice-statistics>

<sup>5</sup> Clin. Orthop. Relat. Res (2009) Feb., 467(2): 352- 357; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628515/>

<sup>6</sup> David M. Studdert, et al., Claims, errors, and compensation payments in medical malpractice litigation, N. Engl. J. Med. 2006; 354, 2024-33.

## **B. There is No Good Reason for Special Venue Rules**

### **1. There is No Plaintiff Friendly Venue**

As discussed above, no venue in Pennsylvania is inherently corrupt or biased. Health care providers cannot claim otherwise. Instead, they state that medical malpractice plaintiffs, should they be allowed the full range of venue choices available to all other Pennsylvanians, will “venue shop,” hinting darkly at some magical venue that is unjustly favorable to medical malpractice plaintiffs.

In fact, no venue in Pennsylvania is favorable to medical malpractice plaintiffs. Statewide, medical malpractice plaintiffs lose, on average, 80% of the time. In many counties, the rate of defense verdicts is above 90%. A defense verdict pattern spanning over 18 years at a rate in excess of 90% is alarming because it suggests it is nearly impossible, no matter how strong the case, for a medical malpractice plaintiff to prevail in those counties.

Beneath the face of the pro-defense verdict statistics lies an even more alarming fact: as a rule, reasonable and experienced medical malpractice lawyers do not knowingly take weak cases anywhere in Pennsylvania and certainly not in counties with an 18-year history of defense verdicts. The cost of medical malpractice litigation and the risk of loss to both plaintiff and plaintiff attorney is simply too high to invest in weak cases or cases with limited economic value. On the contrary, for an experienced medical malpractice lawyer to accept a case that is to be tried in a county with a history of defense bias, there must be compelling evidence of negligence coupled with very serious injury. Thus, those counties demonstrating 90% + defense verdict rates are, as a general proposition, finding for defendants in cases with both strong evidence of liability and serious injuries.

Even in Philadelphia County, the county with the highest plaintiff success rate, defendants win, on average, 65% of the time.<sup>7</sup>

The question is not whether there are venues that are unfairly biased in favor of plaintiffs – there are not - but rather why there are so many that are so clearly biased in favor of defendants. Seen in this light, it is apparent that the “forum shopping” that is happening in Pennsylvania medical malpractice is being done by hospitals and defendants, who recognize the unfair advantage they enjoy in many counties and who, with the aid of effective lobbyists, have succeeded in foisting their choice of forum on the people they injure.

As the Explanatory Comment from the Rules Committee accurately notes with respect to Rule 1006, “[t]he current rule provides special treatment of a particular class of defendants, which no longer appears warranted.”

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<sup>7</sup> <http://www.pacourts.us/news-and-statistics/research-and-statistics/medical-malpractice-statistics>



## 2. Venue Rules Have Not Reduced Medical Malpractice Filings

While true that the number of medical malpractice lawsuits has dropped since 2003, the drop is attributable to other changes made at the same time. Specifically, those measures that increased the cost of malpractice litigation (e.g., the certificate of merit rule) and decreased the economic value of verdicts (reduction in required liability coverage, elimination of the collateral source rule, abrogation of joint liability, reduction to present worth for future earnings loss, and periodic payments of future care expenses) have led plaintiff lawyers to accept fewer meritorious cases because cases with moderate injuries are unlikely to yield an economic result sufficient to warrant the cost of litigation. Thus, there is no reason to believe that applying equal venue rules to medical malpractice defendants will result in an increase in medical malpractice litigation.

This is not to suggest that an increase in medical malpractice litigation is to be feared. On the contrary, there is far more malpractice than there is malpractice litigation and thus, too many Pennsylvanians are denied compensation they are justly owed. Moreover, there is no material problem with excessive litigation. As the New England Journal of Medicine concluded, “Our findings suggest that moves to curb frivolous litigation, if successful, will have a relatively limited effect on the caseload and costs of litigation. The vast majority of resources go toward resolving and paying claims that involve errors. A higher-value target for reform than discouraging claims that do not belong in the system would be streamlining the processing of claims that do belong.”<sup>8</sup>

### Conclusion

No single class of individuals or corporations should be given special treatment and a preferred status. By abrogating the special venue rule, equality and fairness will be restored to the civil justice system.

Sincerely,

Purchase, George & Murphey, P.C.

By:   
Eric J. Purchase

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<sup>8</sup> David M. Studdert, et al., Claims, errors, and compensation payments in medical malpractice litigation, N. Engl. J. Med. 2006; 354, 2024-33.