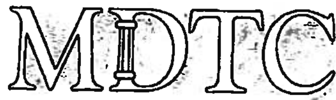

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June 4, 2012

The Honorable Joe Hune
Chairman, Senate Committee on Insurance
P.O. Box 30036
Lansing, MI 48909-7536

Dear Chairman Hune and Members of the Committee:

On behalf of our membership, the Executive Committee of the Michigan Defense Trial Counsel has spent countless hours examining and analyzing the recently introduced package of bills, collectively referred to as the "Patients First Reform Package."

Many of the proposals of the "Patients First Reform Package" are welcome and have broad support. However, there are also some reforms which we do not believe would be improvements on existing rules, some reforms which would adversely affect the interests of our lawyer members, and some reforms which we believe may be a detriment to the civil justice system, as a whole.

We thank you for the opportunity to share our perspectives and positions on these bills and their various sub-parts.

Statement of Interest

The Michigan Defense Trial Counsel ("MDTC") is a non-profit association organized and existing to advance the knowledge and improve the skills of civil defense lawyers, to support improvements in the adversary system of jurisprudence in the operation of the Michigan Courts as a whole, and to broadly address the interests of the legal community in Michigan. A significant portion of our membership practices in the defense of Medical Malpractice Claims. Indeed, a substantial number of our member lawyers do nothing but Medical Malpractice Defense work.

While our lawyer members routinely represent individuals, corporations, doctors and hospitals in negligence actions, the Michigan Defense Trial Counsel is an organization of lawyers, only. The Executive Committee and Board Members owe our fiduciary obligations to the lawyer members of the Michigan Defense Trial Counsel, exclusively. We advocate on behalf of our members, first and foremost.

We now offer our views and positions on the Bills and their various sub-parts.

The Position of the Michigan Defense Trial Counsel on the Emergency Room Immunity Bill, SB 1110: Opposed

This bill seeks to immunize Emergency Room Doctors and Obstetrical Doctors from liability in medical malpractice actions except in extremely limited circumstances, circumstances so rare it is difficult to imagine a scenario where the burden of proof proposed by SB 1110 could realistically ever be met. SB 1110 seeks to carve an exception to immunity in cases where a claimant can prove "gross negligence" by "clear and convincing evidence." Overcoming just one of these hurdles is very difficult under Michigan law. Overcoming both simultaneously would be virtually impossible. For this reason, we oppose SB 1110.

Under Michigan law, "gross negligence" is much more than an egregious mistake, carelessness or a colossal blunder. Rather, it is defined as "conduct so reckless as to demonstrate a substantial lack of concern for whether injury results." MCL 691.1407(7)(a). In other words, in order to meet the gross negligence standard of SB 1110, a medical professional would essentially have to not care one way or the other about the outcome for a patient while negligently rendering care in an Emergency Room or Obstetrical Unit. As long as a medical professional could show he or she was at least trying to help, without a regard for whether the standard of care was met, gross negligence could not be shown. That alone would be an exceedingly difficult burden to meet.

Furthermore, imposing a "clear and convincing" evidentiary burden on top of a "gross negligence" standard would further heighten the difficulty of a claimant to ever escape the immunity proposed to be conferred by SB 1110. "Clear and convincing" evidence does not amount to proof beyond a reasonable doubt in the criminal context, but is a significantly higher evidentiary burden than the traditional preponderance of the evidence standard that currently applies in medical malpractice cases and for negligence actions generally. See, for example, Reed v. Breton, 475 Mich. 531 (Mich. 2006) (analyzing the hierarchy of these three evidentiary burdens). The preponderance of the evidence standard has worked well for the State of Michigan and we fail to see why it should be altered and in this instance heightened to make Medical Malpractice Actions, which are already difficult enough, even more difficult to prove.

It is the view of the Michigan Defense Trial Counsel that SB 1110 should not be adopted. Passage of this immunity bill would unfairly restrict access to the civil justice system for citizens of Michigan. We would also note that some hospitals and health care systems have also opposed SB 1110 on grounds that its passage would not be in the best interests of patients in Michigan nor would it foster an improvement of medical care in our communities. We share that view.

Provisions of the Patients First Reform Package That Are Favored By the Michigan Defense Trial Counsel

Next, let us identify the bills and provisions that the MDTC favors. Most significantly, we believe the fix of the decision in Nation v. W D E Electric Co, 454 Mich. 489 (1997) by SB 1115 remedies an inequity that has existed in the law far too long by providing that the reduction to present value is calculated using a compounded interest rate. Currently, plaintiffs are permitted to increase their future damages by a compounded inflation rate, but when the reduction to present cash value occurs, interest is not compounded. This fails both tests of fairness and common sense. We support SB 1115's requirement that future damages be reduced to present cash value at a compounded interest rate.

Second, the MDTC supports the cap on extensions of the Statute of Limitations in SB 1118. In the case of Eggleston v Bio-Medical Applications of Detroit, Inc, 468 Mich 29 (2003), the Supreme Court allowed plaintiffs to extend the statute of limitations almost indefinitely in wrongful death actions by continual new appointments of Personal Representatives and repeated issuances of Letters of Authority. SB 1118 seeks to remedy this unfairness, but only for wrongful death actions arising out of alleged medical malpractice. The Eggleston rule is unfair for all wrongful death actions. We support this provision of SB 1118 and, if anything, feel it does not go far enough because it does not apply across the board to all Wrongful Death Actions.

That is also the consensus in another aspect of SB 1118, which provides, in an action for medical malpractice, that interest on an award of costs or attorney fees is not calculated for any period before the entry of the judgment. Interest on an award of costs or attorney fees should be calculated in the same fashion in any personal injury action, regardless of whether the tort involves product liability, negligent operation of a motor vehicle, premises liability or any other tort seeking to redress a personal injury. We support this provision in principle but believe that if it is applied in Medical Malpractice cases it should be applied in other personal injury actions as well.

We also approve of the amendment to MCL 600.2912e in SB 1118, which changes the time limitation for the Defendant's filing of an Affidavit of Meritorious Defense from 91 days of the plaintiff's *filing* of the Affidavit of Merit to 91 days within *service*.

We agree with the amendment of MCL 600.6306A under SB 1115 which requires the Trial Court to calculate the ratio of past non-economic damages to future non-economic damages, in order to prevents plaintiffs from unfairly lumping all capped non-economic damages as past damages and therefore subject to the award of pre-judgment interest, as opposed to the award of future non-economic damages which are not subject to pre-judgment interest.

We agree with the portion of SB 1115 providing that damages for the loss of society and companionship and loss of consortium are non-economic damages and therefore subject to the damages cap under MCL 600.1483.

We do not, however, believe that the loss of household services can fairly be included within the definition of non-economic damages as proposed by SB 1115. In colloquial terms, this appears to us to be calling an apple an orange. The loss of household services is an objectively quantifiable economic loss, not a tough to define, subjective loss such as pain and suffering or mental anguish. We also are concerned that including household services within the category of non-economic damages would conflict with other areas of Michigan law, including the Products Liability Statute, MCL 600.2945(c), which defines "economic loss" as including "costs of obtaining substitute domestic services."

The Position of the Michigan Defense Trial Counsel on the Medical Judgment Rule and Elimination of the Lost Opportunity Doctrine, SB 1116: Opposed

After careful evaluation of SB 1116, we believe that the proffered intent underlying the bill does not coincide with the statutory language found in SB 1116, particularly as to the so called "Medical Judgment Rule." This common law rule, which holds that medical professionals are not liable when the generally accepted standard of care allows them to choose among more than one different treatment or diagnostic options, exists in the law already, as most famously articulated by the case of Rytkonen v Lojacono, 269 Mich 270, 275 (1934) ("Where there is an opportunity for choice, the doctor is not guilty of negligence in using a method so recognized. . . .")

The MDTC is entirely sympathetic to the needs of medical professionals to be insulated from liability in cases where the doctor did everything right and followed the standard of care but the patient still suffered an adverse outcome. Rytkonen addresses this beneficial rule as does Michigan Civil Jury Instruction 30.04, which provides as follows:

> Medical Malpractice: Cautionary Instruction on Medical Uncertainties
>
> There are risks inherent in medical treatment that are not within a doctor's control. A doctor is not liable merely because of an adverse result. However, a doctor is liable if the doctor is negligent and that negligence is a proximate cause of an adverse result.

This rule of law, which essentially holds that doctors cannot guarantee outcomes, recognizes that a doctor will not be held liable for a bad outcome for a patient if the doctor's conduct in picking among numerous acceptable alternatives complied with the generally accepted standard of care. This rule already exists and is entrenched in Michigan law.

The operation of the Medical Judgment Rule is best understood according to the facts of that seminal case. In Rytkonen, the decedent suffered an infection and subsequently died following surgery. A drainage catheter was necessary for the procedure and the defendant doctor used tape to secure the tube to the decedent's chest. Ultimately, the tape came undone, the tube slipped into the surgical entry point and the patient died from infection. The decedent's estate sued the doctor arguing that the defendant was negligent for failing to use a safety pin to additionally secure the tube which the plaintiff claimed would have prevented the tube from slipping in.

The expert testimony, however, was that the generally recognized standard of care for securing the tube was to use **either** tape **or** a safety pin **or** both. In other words, the doctor had a choice as to which method to employ, any one of which fully complied with the generally recognized standard of care, even though it ultimately turned out that the choice did not end well for the patient.

The Supreme Court of Michigan articulated the Medical Judgment Rule which shields medical professionals from liability as follows: "Where there is an opportunity for choice, the doctor is not guilty of negligence in using a method so recognized, even though all his local contemporaries may employ another method." Id., p 275. In other words, because the doctor's selection of tape as a fastener was recognized as an acceptable choice, he could not be found liable in negligence for following the generally recognized standard of care for doctors. The same would have been true of a doctor who used just a safety pin or a doctor who had used both, even though ultimately the patient suffered an infection that killed him because any one of the three options was accepted as meeting the standard of care.

The recognition that the doctor complied with the standard of care by selecting one acceptable option among three is what could potentially shield him from liability. It was not because the doctor acted in good faith or with the patient's best interests in mind. The doctor's subjective intent or beliefs had absolutely nothing to do with the Medical Judgment Rule. We therefore do not see why SB 1116 abandons analysis of the standard of care and instead ventures into subjective speculations as to what the medical professional was thinking when a certain choice was made.

First, the language of SB 1116 itself does not refer to the Standard of Care applicable to medical professionals and instead turns the question of negligence into whether the medical professional had a reasonable belief he or she was acting in the best interest of the patient. The Bill attempts to immunize doctors from liability for the exercise of a professional judgment and defines professional judgment as when a medical professional "acts with a reasonable and good-faith belief that the person's conduct is both well founded in medicine and in the best interests of the patient." Again, we agree that doctors who comply with the standard of care should not be held liable in negligence, we just do not believe that SB 1116 encompasses this rule.

Importantly, SB 1116 proposes an entirely subjective standard and would absolve a doctor from liability even if the medical judgment was not actually well founded in medicine; instead, all that would be required to shield the professional from liability would be that the doctor subjectively believed the choice was well founded. The fact that this consideration would be decided without reference to whether the doctor complied with the standard of care and used the skill ordinarily possessed by the average member of his or her profession is a deviation from existing Medical Malpractice jurisprudence. We do not know of such a rule existing in any other jurisdiction, either.

How could a litigant or anyone else get into the mind of the doctor and opine whether he or she considered the patient's best interests? What if the negligent doctor testifies that she did, in fact, act in good faith and believed what she was doing would help the plaintiff even though the doctor fell egregiously below the standard of care universally recognized by other doctors and medical journals? How could such testimony ever be rebutted? These are legitimate concerns with the current formulation of the Medical Judgment Rule in SB 1116.

To conclude, we believe the currently proposed formulation of the Medical Judgment Rule in SB 1116 constitutes an unfavored departure from existing law. We agree with the hospitals and health care systems who have opposed SB 1116 on grounds that it would not advance the interests of patients nor would its implementation improve the practice of medicine in our communities.

We also do not believe that an across the board elimination of the "lost opportunity" doctrine is warranted due to difficulty courts have faced in resolving these claims. "Lost opportunity" or "lost chance" claims are recognized across a majority of jurisdictions across the country and Michigan's current cut off that the lost chance must have greater than 50% is a reasonable limitation under MCL 600.2912a. Eliminating the phrase "unless the opportunity was greater than 50%" could be construed broadly to eliminate medical malpractice claims unless the patient had a 100% chance of a successful outcome.

Additional Provisions of the Patients First Reform Package That The Michigan Defense Trial Counsel Does Not Support Or Takes No Position On

SB 1115's amendment of MCL 600.6306 to provide for the offset of medical costs as collectible collateral sources also seems to apply in this single context, only, but not for personal injury actions, generally. For all personal injury actions, MCL 600.6306 currently provides that future economic

damages must be reduced by collateral source payments determined to be collectible payments, but seems to exclude ***medical and other health care costs from this collateral source reduction***. Proposed 6306A(d) provides that an award for future medical and other health care costs must be reduced by collateral source payments, ***but this only applies to medical malpractice actions***. If this provision is enacted, we do not see why it would only apply in Medical Malpractice actions.

One aspect of SB 1115 is confusing to us. Pursuant to the proposed amendment of MCL 600.6306(A)(3) in SB 1115, the total judgment is reduced by the amount of settlements paid by all joint tortfeasors, including joint tortfeasors who are not parties to the action and who are not persons described in 5838a(1). The amount to be deducted is allocated proportionately between past and future damages. The reference to "joint tortfeasors who are not persons described in section 5838a(1)" is confusing in light of MCL 600.2956, 600.6304(4) and 600.6304(6), which provisions have abolished joint and several liability in personal injury actions, medical malpractice actions excluded under MCL 600.6304(6). Moreover, a personal injury action is not deemed to be one for medical malpractice, unless it is filed against persons described in MCL 600.5838a(1). The only persons who could be joint tortfeasors with a medical malpractice defendant would be other persons who are described in MCL 600.5838a(1). It is confusing why this bill would refer to "joint tortfeasors who are not persons described in section 5838a(1)."

We envision potential difficulty from the implementation of SB 1117 and the new standards for expert witness testimony. In particular, this bill imposes requirements for the qualifications of experts who testify for or against ***unlicensed*** health professionals. It appears that this legislation is aimed at occupations such as medical assistants, pharmacy technicians and nurse aides who are not required to be licensed in Michigan (nurse aides receive training in programs approved by the State of Michigan, and are tested and certified by a private company named Prometric). Basically, this bill imposes the same limitations upon experts who testify for or against ***unlicensed*** health professionals as are currently imposed upon experts who testify for or against ***licensed*** health professionals. Under this legislation, a registered nurse would not be allowed to testify in support of a nurse aide whom he or she supervises, a physician could not testify in support of a medical assistant employed and supervised by him or her, nor could a pharmacist testify on behalf of a pharmacy technician. This would make bringing Medical Malpractice actions more difficult and also more difficult to use expert witnesses to defend against them.

Moreover, it appears highly doubtful that an unlicensed health professional could be deemed to be a specialist under Michigan law. The Supreme Court has held that a "specialist" is somebody who can potentially become board certified. Woodard v. Custer, 476 Mich. 545, 561, 719 N.W.2d 842, 851 (2006). As of this writing, we are unaware of any specialty boards which certify unlicensed health professionals.

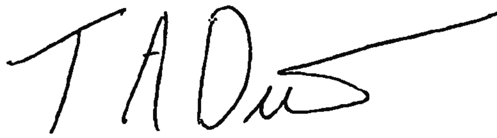
The purpose of proposed MCL 600.2912(2) is not apparent. We are unaware of any case law which states that someone who engages in or assists in medical treatment cannot be sued for malpractice if he or she engages in the practice of the health profession in a sole proprietorship, partnership, professional corporation, or other business entity. It appears that this provision seeks to remedy a problem which does not exist.

Conclusion

The above analysis was developed over the collective course of hundreds of hours of research and study into the Patients First Reform Package and represents the view of the Executive

Committee of the Michigan Defense Trial Counsel. We greatly appreciate the opportunity given to us to offer our views and are available for further consultation or analysis if needed.

Sincerely



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HB 5063, Amending MCL 691.1407 (2000) MSU Physician Immunity

http://www.legislature.mi.gov/documents/1999-2000/billanalysis/House/htm/1999-HLA-5063-A.htm

REVISE HOSPITAL EXCEPTION TO

GOVERNMENTAL IMMUNITY

House Bill 5063 (Substitute H-7)

House Bill 5803 as introduced

Sponsor: Rep. Larry Julian

Committee: Family and Civil Law

First Analysis (5-30-00)

THE APPARENT PROBLEM:

The governmental immunity act gives governmental agencies immunity from tort liability (i.e. protection against lawsuits) when engaged in the exercise or discharge of a governmental function and gives immunity to officers, employees, members, and volunteers acting within the scope of their authority as long as their conduct does not amount to gross negligence. However, the act contains a number of exceptions to this granting of immunity. Significantly, the act does not grant immunity to governmentally owned or operated hospitals or county medical care facilities and the agents or employees of these hospitals or facilities, unless they are owned and operated by the Department of Community Health or a hospital operated by the Department of Corrections.

These provisions were put in their current form by 1986 amendments, part of large tort reform package. The amendments created what some knowledgeable observers describe as an unintentional loophole and granted immunity from malpractice lawsuits to a certain category of doctors. This is because the language of the act exempts from immunity governmentally owned hospitals and the agents or employees of these hospitals and thus appears to grant immunity to doctors who are governmental employees performing a governmental function but who are not agents or employees of governmentally owned or operated hospitals. Courts have dismissed cases brought against such doctors, notably doctors employed by Michigan State University practicing in private hospitals. (Michigan State has medical schools but does not operate a hospital of its own, using instead private hospitals in the community.) This means that doctors at MSU have been considered immune from malpractice lawsuits when doctors

affiliated with the University of Michigan or Wayne State University, which operate their own hospitals, are not immune. Critics say that the hospital exception to governmental immunity was not intended to provide immunity to university-employed doctors just because the university employer does not operate a hospital, and they have urged the enactment of legislation to close this loophole.

THE CONTENT OF THE BILLS:

House Bill 5063 would amend the governmental immunity act (MCL 691.1407) so that it would provide that it did not grant immunity to a governmental agency or an employee or agent of a governmental agency with respect to providing medical care or treatment to a patient, except medical care or treatment provided to a patient in a hospital owned or operated by the Department of Community Health or a hospital owned or operated by the Department of Corrections. The bill specifies that it would apply only to a cause of action arising on or after the effective date of the bill. (See Background Information for the current immunity provision.)

Further, the bill would make an additional change in the language of the act that has been described by the Legislative Service Bureau as having no substantive effect, as it essentially implements a decision of the Michigan Supreme Court (*Dedes v Asch*). One of the conditions required for the extension of governmental immunity is that the officer's (employee's, member's, or volunteer's) conduct "does not amount to gross negligence that is the proximate cause of the injury or damage" (emphasis added). The bill would change this phrase to refer to conduct that "does not amount to gross negligence that is a proximate cause of the injury or damage" (emphasis added). The supreme court has said "the" means "a" for the purposes of this provision.

House Bill 5803 would amend Section 20175 of the Public Health Code (MCL 333.20175) to include within the current confidentiality provisions related to professional review functions those records, data, and knowledge collected for or by individuals assigned a professional review function in an institution of higher education that has colleges of osteopathic and human medicine (e.g., Michigan State University). Currently, the code applies to professional review functions "in a health facility or agency." The code says the records are confidential, can be used only for the purposes provided under the code, and are not subject to court subpoena.

BACKGROUND INFORMATION:

** The governmental immunity act currently says: "This act does not grant immunity to a governmental agency with respect to the ownership or operation of a hospital or county medical care facility or to the agents or employees of such a hospital or county medical care facility." The act provides definitions of "county medical care facility" and "hospital", and says that the term "hospital" does not include a hospital owned or operated by the Department of Community Health or a hospital operated by the Department of Corrections.

** House Bill 4629 of the 1997-98 legislative session addressed this issue. The bill passed both the House and the Senate, but in different versions. Among other differences, the House version was retroactive to 1986 while the Senate version was prospective, as House Bill 5063 (H-7) would be.

** This issue was the subject of decisions by both the Michigan Court of Appeals and the Michigan Supreme Court in *Vargo v Sauer and Sisters of Mercy Health Care Corporation*. The lawsuit involved a malpractice case against an MSU-employed physician and a private hospital. The appeals court in February of 1996 agreed with the circuit court decision to dismiss the case, concluding that since the physician was a governmental employee and was not subject to the hospital exemption (or any other exemption) from immunity, he was entitled to immunity as long as he had been acting within the scope of his authority, the agency for which he was working was engaged in a governmental function, and his conduct was not so reckless as to show a substantial lack of concern for whether an injury resulted. The court concluded the physician met the criteria and was entitled to immunity. The supreme court decision

in April of 1998, on the other hand, reversed the trial court's grant of summary disposition and remanded the case to circuit court for further proceedings. The court agreed with the appeals court that the physician was performing a governmental function as a university-employee for the purposes of the immunity statute, but also opined that "an individual may serve two masters simultaneously" and that there remained a material question of fact (to submit to the jury) about whether the physician was also acting as an agent for the private hospital.

FISCAL IMPLICATIONS:

Fiscal information is not available.

ARGUMENTS:

For:

House Bill 5063 would correct an unintended loophole in the governmental immunity act, stemming from 1986 amendments, that prevents people from suing doctors for malpractice if they are university employees practicing at a private (or non-university) hospital if they are affiliated with a university that does not operate a hospital. The practical effect of this is to prevent people from suing doctors affiliated with Michigan State University but allowing lawsuits against doctors affiliated with the University of Michigan and Wayne State University, simply because MSU does not have its own hospital but uses private facilities. This is obviously unfair. Doctors should be held responsible for negligent acts, and special immunity should not be granted to doctors who work for universities based on whether or not the university operates a hospital. Moreover, people seeking treatment from protected doctors are not likely to know that their providers are insulated from malpractice lawsuits. Knowledgeable observers say that had someone raised the issue during the legislative discussions over the 1986 amendments, this category of doctors would never have been granted immunity from lawsuits.

For:

House Bill 5803 would essentially provide the same peer review confidentiality protections to peer review activities at Michigan State University (or any university that operates colleges of osteopathic and human medicine) that are already available in the Public Health Code for professional review functions in a health facility or agency. (MSU does not operate a health facility or agency.) Information related to peer review is not subject to court subpoena.

POSITIONS:

Michigan State University supports the two-bill package. (5-25-00)

The Michigan Trial Lawyers Association supports the bills. (5-25-00)

Analyst: C. Couch

This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.

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May 21, 2012

The Honorable Joe Hune
Chairman, Senate Committee on Insurance
PO Box 30036
Lansing, MI 48909-7536

RE: Malpractice Reform Legislation (Senate Bills 1115, 1117, 1118 and 1110, 1116)

Dear Chairman Hune and Members of the Committee:

Thank you for the opportunity to comment on the Malpractice Reform Legislation. As Vice President of the Henry Ford Health System Risk Finance & Insurance Services Program, I would offer the following comments on specific bills for your consideration.

Our Henry Ford risk management program covers 5 hospitals, multiple emergency care centers and 1,100 physicians in 40 specialties who staff the Henry Ford hospitals and 29 medical centers. We provide care to approximately 1 million patients annually.

We have been very supportive of the malpractice provisions in current law, and we have seen improvement in our malpractice costs. However, issues remain in the liability statutes which should be addressed. We believe that fair and appropriate tort reform; when combined with the Henry Ford Health System commitment to improving quality, its approach to integrated medicine and its digital medical record systems have all played an essential part in an improved liability picture for Henry Ford Health System. However, inequities remain in the ambiguity and interpretation of several medical malpractice statutes. Additional changes would reduce inappropriate malpractice costs without placing patients at risk or preventing patients from obtaining access to remedies in the court system. It is from this perspective that we would offer the following comments.

SB 1115 – Provides several changes which appear both fair and reasonable, and we are in support of them:

- That following a verdict, the "gross present cash value" of the award would be reduced to present value "compounded annually"**(MCL 600.1483(3))**
- That the noneconomic damage cap would expressly include "household services." **(MCL 600.6306(2))**

SB 1117 – We support the proposed change:

- That the qualifications required for expert testimony against licensed professionals would apply equally to non-licensed health care professionals. **(MCL 600.2169(2))**

SB 1118 – Provides several changes which appear both fair and reasonable, and we are in support of them:

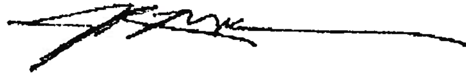
- That the ability of a claimant in a wrongful death claim to add additional years to the savings provision of the statute of limitations through the appointment of a successor personal representative would be reasonably limited to a term of years. **(MCL 600.5852 (2)-(4))**
- That interest on costs or attorney fees awarded under statute or court rule would not be calculated for any period before entry of the judgment. **(MCL 600.2912e (8))**

We do not support **SB 1110** and **SB 1116,** as in our opinion they have the potential to work against the best interests of our patients and would do nothing to foster quality medicine or responsible medical practice.

In our observation, the malpractice climate in Michigan has seen improvement through the reforms to Michigan law enacted in 1986, 1994 and 1996. However, more can be done. The improvements we support, contained within **SB 1115, 1117** and **1118,** which have been presented for consideration by the Committee, will assist to make Michigan more attractive for physician practice and place Michigan in a more favorable position to reverse projected future physician workforce shortages.

Thank you for providing this opportunity to comment.

Sincerely,



John R. Mucha, JD, CPCU
Vice President
Risk Finance & Insurance Services
Henry Ford Health System

cc. Senate Committee on Insurance

SBM STATE BAR OF MICHIGAN

NEGLIGENCE LAW SECTION

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October 24, 2013

House Judiciary Committee:

The Negligence Section of the State Bar is interested in current tort reform legislation pending before your Committee. We are a voluntary organization that represents over 2,000 plaintiff and defense attorneys in Michigan. The governing council is comprised of an equal number of plaintiff and defense attorneys, so as to achieve a balanced perspective of civil law in Michigan. Though our views do not necessarily represent the State Bar, our members actively practice in medical malpractice litigation and have insight into issues relevant to your Committee.

The Negligence Council has considered HB 4354 (MCL 600.2912i), as we did earlier when the legislation was offered as SB 1110. At that time, the Negligence Section of the State Bar opposed SB 1110 and was very concerned about the effect the proposed legislation would have on the medical community, including physicians, hospitals, and the public. Our view has not changed.

POSITION: *OPPOSED*

HB 4354 would provide immunity for medical care in the emergency department or obstetrical unit of a hospital. The bill requires **clear and convincing evidence of gross negligence**, an impossible standard. The bill extends immunity throughout the hospitalization to all practitioners who come into contact with the patient.

Approximately two years ago, the House Judiciary Committee appointed a sub-committee chaired by Representative Kurt Heise to explore and discuss the ramification of statutes which included a gross negligence standard. The sub-committee was unable to reach a consensus on a new and workable definition of the phrase 'gross negligence'. It was evident to those of us who attended the meetings that there was a general misunderstanding as to the meaning and effect of gross negligence.

HB 4354 bill would impose the clear and convincing standard on top of gross negligence, creating a legal morass and a standard of conduct unheard of in Michigan jurisprudence. It would be virtually impossible to prove gross negligence in a medical malpractice setting and compelling a litigant to also prove gross negligence by clear and convincing evidence would create absolute immunity favoring the hospital and doctors. No suit for medical malpractice could ever be successful, no matter how meritorious.

SBM State Bar of Michigan

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The Negligence Section believes that if HB 4354 becomes law, many doctors will simply abandon office patients and send them to the emergency room since there would be immunity for treatment. It also appears the major group affected by the obstetrical provision of the statute is women and children; a vulnerable group. Finally, we are concerned the law would encourage sub-standard doctors to come to Michigan, and believe current programs successfully implemented by local hospitals to police doctors would be jeopardized.

For these and other reasons, the Negligence Section of the State Bar opposes HB 4354. As always, our Section stands ready to assist in any legislative ideas which may come before your Committee.

Sincerely yours,

Steven B. Galbraith
Chair, SBM Negligence Law Section

SBG/mkf

Mich HB 4354 – Fact Sheet
"The ER Immunity Bill"

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The History of the ER Immunity Bill Reintroduced for the 3rd Time as HB 4354

The ER Immunity Bill, now HB 4354,[1] is on round three (3) in the Michigan Legislature. Senator Kahn originally pushed and introduced the identical bill in 2009 as SB 858.[2] SB 858 failed a Senate Judiciary discharge vote 1/5.[3]

Senator Kahn again pushed the identical bill in 2012 as SB 1110.[4] Chair of the Senate Insurance Committee, Senator Hune, while taking months of testimony on other malpractice bills, took no direct testimony on SB 1110. This was due in no small part to overwhelming opposition to this bill from members of the medical profession, hospitals, the Michigan Defense Trial Bar, the State Bar of Michigan Negligence Section, the Oakland County Bar Association and virtually every witness where the issue came up during testimony on the other bills; everyone opposed SB 1110, now HB 4354.

Henry Ford Hospital Systems Opposes HB 4354

John Mucha, Vice President, Risk Finance & Insurance Services, Henry Ford Health System in May 2012 wrote a letter to Chairman Hune and the Senate Insurance Committee regarding 5 medical malpractice bills referred to their committee. The relevant portion of that letter states:

> We do not support SB 1110... as in our opinion [it has] the potential to work against the best interests of our patients and would do nothing to foster quality medicine or responsible medical practice.[5] (Emphasis Added).

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[1] February 28, 2013, Introduced by Reps. Walsh, Howrylak, Haines, Lyons and Johnson and referred to the Committee on Judiciary.
[2] September 22, 2009, Introduced by Senators Kahn, Garcia, Jansen, Kuipers, Barcia, Stamas, George and Switalski and referred to the Committee on Judiciary.
[3] Journal of the Senate, November 10, 2010, No 87, page 1912.
[4] May 3, 2012, Introduced by Senators Kahn, Caswell, Jones, Colbeck and Moolenaar and referred to the Committee on Insurance.
[5] John Mucha letter to Senator Hune, May 21, 2012.

Michigan Defense Trial Counsel (MDTC) Opposes HB 4354

Timothy Diemer, President of the Michigan Defense Trial Counsel (MDTC), whose members defend ER Physicians, also wrote a letter to Chairman Hune. While lengthy, the analysis is worth a careful read:

The Position of the Michigan Defense Trial Counsel on the Emergency Room Immunity Bill, SB1110: Opposed

This bill seeks to immunize Emergency Room Doctors and Obstetrical Doctors from liability in medical malpractice actions except in extremely limited circumstances, circumstances so rare it is difficult to imagine a scenario where the burden of proof proposed by SB 1110 could realistically be met. SB 1110 seeks to carve an exception to immunity in cases where a claimant can prove "gross negligence" by "clear and convincing evidence," Overcoming just one of these hurdles is very difficult under Michigan law. Overcoming both simultaneously would be virtually impossible. For this reason, we oppose S8 1110. (Emphasis Added).

Under Michigan law, "gross negligence" is much more than an egregious mistake, carelessness or a colossal blunder. Rather, it is defined as "conduct so reckless as to demonstrate a substantial lack of concern for whether injury results." MCL 691.1407(7)(a). In other words, in order to meet t e gross negligence standard of SB 1110, a medical professional would essentially have to not care one way or the other about the outcome for a patient while negligently rendering care in an Emergency Room or Obstetrical Unit. As long as a medical professional could show he or she was at least trying to help, without a regard for whether the standard of care was met, gross negligence could not be shown. That alone would be an exceedingly difficult burden to meet. (Emphasis Added).

Furthermore, imposing a "clear and convincing" evidentiary burden on top of a "gross negligence" standard would further heighten the difficulty of a claimant to ever escape the immunity proposed to be conferred by SB 1110. "Clear and convincing " evidence does not amount to proof beyond a reasonable doubt in the criminal context, but is a significantly higher evidentiary burden than the traditional preponderance of the evidence standard that currently applies in medical malpractice cases and for negligence actions generally. See, for example, *Reed v. Breton*, 475 Mich. 531 (Mich. 2006) (analyzing the hierarchy of these three evidentiary burdens). The preponderance of the evidence standard has worked well for the State of Michigan and we fail to see why it should be altered and in this instance heightened to make Medical Malpractice Actions, which are already difficult enough, even more difficult to prove. (Emphasis Added).

It is the view of the Michigan Defense Trial Counsel that SB 1110 should not be adopted. Passage of this immunity bill would unfairly restrict access to the! civil justice system for citizens of Michigan. We would also note that some hospitals and health/care systems have also opposed SB1110 on grounds that its passage would not be in the best interests of patients in Michigan nor would it foster an

improvement of medical care in our communities. We share that view.[6] (Emphasis Added).

The Oakland County Bar Association (OCBA) Opposes HB 4354

The Oakland County Bar Association (OCBA) is probably the largest county bar association in the state with over 3,000 members.[7] Their membership is diverse with no special section interested in such matters other than the Medical-Legal Committee, which is composed of physicians and attorneys who deal with inter-professional relationships and matters of concern to both professional groups.[8] Nevertheless, SB 1110 caught the attention of its Legislative Committee. The following is their published analysis and opposition: [9]

Summary of Proposed Legislation

MCL 600.2912l provides immunity for medical care in the emergency department or obstetrical unit. The bill requires clear and convincing evidence of gross negligence, an impossible standard. The bill extends immunity throughout the hospitalization to all practitioners who come into contact with the patient. (Emphasis Added).

Position Advocated By Committee (And Whether Such Position Was Unanimous or Otherwise)

Opposed Unanimously
(Emphasis Added).

Rationale for Position

Should this legislation pass, it is believed that many doctors would simply send difficult patients to the ER since there is immunity for treatment. Additionally, it is believed that an unintended consequence is that the law would induce sub standard doctors to come to Michigan to practice knowing that they would have immunity. It is important to note that the major group affected by the OB portion of the statute is women and children who would lose any recourse to file a case arising from issues with obstetric care provided. (Emphasis Added).

The State Bar of Michigan's Negligence Section Opposes HB 4354

The State Bar of Michigan's Negligence Section came to the same conclusion:

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[6] Timothy Diemer, President of the Michigan Defense Trial Counsel, June 4, 2012 letter to Senator Hune.
[7] http://www.ocba.org/aboutus.id.3.htm
[8] http://www.ocba.org/Committees.id.13.htm
[9] May 23, 2013 Oakland County Bar Association Report of Requested Legislative Action

MCL 600.2912l (SB1110), which provides immunity for medical care in the emergency department or obstetrical unit. **Position: Opposed**[10]

Michigan State Medical Society
Former Chief of Risk Management Opposes HB 4354

It is no wonder witnesses were not called to testify in support of SB 1110; there would likely have been none, or at least no credible witnesses. Even the Michigan State Medical Society's former Chief of Risk Management, Julia Pollex, testified that SB 1110 and the others that created immunity for poor care was a huge mistake for Michigan. Ms. Pollex did not mince words:

> I conducted approximately 150 to 200 presentations and seminars a year, teaching procedures and protocols to implement in a medical practice to promote quality care, prevent medical misadventures, and in the event of such an occurrence, minimize the injury and the damage.
>
> Behavioral experts tell us that consequences are the greatest influence on one's behavior. I know of no parenting book in which consequences are not the backbone advice. The behavior and actions of physicians are no exception. The threat of a malpractice lawsuit DOES affect the quality of care provided.
>
> Why is a person injured as a result of poor medical judgment or skill to be denied legitimate compensation for damages, yet should a plumber ruin a homeowner's floor due to faulty work, he could be sued and required to reimburse the homeowner for the repair of the damages. A Michigan citizen's hardwood flooring is more valuable than his health and well-being?
>
> Michigan will be flooded with sub-standard physicians – those who are unable to get insurance in other states will look to Michigan as a Mecca. Can't practice in New York because your knowledge, judgment and skills are severely flawed? Heck, Pure Michigan.
>
> It is because of this that I fear eliminating the threat of malpractice will be disastrous consequence to the population of Michigan.[11] (Emphasis Added).

Katie Dama Jaskolski Opposes HB 4354[12]

Perhaps the most compelling testimony, which reduced the sound level in the Senate Hearing Room of 300 people to a pin drop, was that of Katie Dama Jaskolski on May

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[10] Negligence Law Section News Flash, Issue No 5, May 2012.

[11] Julia Pollex, former Chief of Risk Management for the Michigan State Medical Society (MSMS) letter to Senator Brandenburg, July 10, 2012.

[12] See written submission of Katie Dama Jaskolski, her Senate Insurance Com testimony of May 22, 2012, and that of her attorney, Norman D. Tucker of the same day.

22, 2012. Katie is a teacher at Wexford Montessori Magnet School. She holds a Bachelor of Arts from Michigan State University and a Masters in Curriculum from St. Catherine University in Minneapolis, MN.

In 1999, Katie was a junior at Sexton High School, Lansing and was ranked nationally in gymnastics. She was being recruited by Michigan State University, Rutgers University, Brown University, Air Force Academy, Western Michigan University and Eastern Michigan University. Unfortunately, while performing a routine on the uneven bars, she injured her left elbow; a torn elbow ligament. She sought treatment with a physician employed by Michigan State University School of Medicine. At the time, MSU physicians were still considered governmental employees and their conduct was judged by the same gross negligence standard being proposed in HB 4354.

After surgically opening the injured area, the surgeon, Douglas Dietzel DO, decided he would have to do a tendon transfer. He had never performed this surgical procedure so he had a textbook brought to the OR, which he opened and referenced as the procedure proceeded. There are 3 major nerves in the arm which control arm and hand movement; of the 3 the median nerve is considered one of the most important. Instead of removing the palmaris longus tendon, with which he intended to perform a tendon transplant, he removed the median nerve. At that moment Katie's gymnastics career was over and she would never again have normal function of her left arm and hand.

Dietzel's attorneys filed a motion to dismiss the case claiming it was impossible for Katie to prove that his conduct rose to the level of gross negligence. The trial court agreed and the case was dismissed. The decision was appealed and the court's opinion is what every patient can expect if HB 4354 becomes the law.[13]

> The trial granted the motion, finding that reasonable minds could not disagree that defendant's conduct constituted more than ordinary negligence.[14]
>
> Plaintiff emphasizes that defendant had never performed this specific graft procedure; however, she cites no authority that holds that a physician acts in a grossly negligent manner by performing a procedure for the first time.
>
> Gross negligence is defined as "conduct so reckless as to demonstrate a substantial lack of concern for whether an injury results." MCL 691.1407(2)(c).
>
> In order to show a question of fact as to whether defendant acted in a grossly negligent manner, the plaintiff was required to present evidence that defendant simply did not care about plaintiff's health and safety. (Emphasis Added).[15]

[13] *Dama v Dietzel DO*, Mich App, Unpublished, April 7 2005, No 260110. Application for Leave to Appeal to the Supreme Court was denied.

[14] There was no dispute that removing the median nerve was a violation of the standard of reasonable care.

Gross negligence is much more than "really bad medicine"; it has a legal definition. If Katie could not prove gross negligence, no one can – it will be immunity pure and simple.

If HB 4354 becomes the law, the feelings expressed by Katie will quickly spread throughout the state:

> In addition to the physical injuries, the anger and frustration that comes with unfairness in the law is also a permanent injury.
>
> Being a victim of such laws, this is something that I cannot comprehend. I cannot understand why any legislature would want to pass a law that would, in essence, give all doctors a license to commit malpractice on their patients. This will not make medicine safer, but hazardous to those who need the best care possible. If this is true, and if this law were to pass, I only hope that what happened to me doesn't happen to you or a loved one.[16] (Emphasis Added)

2013 Nothing Has Changed
Everyone Still Opposes HB 4354

Senator Kahn held a meeting of all interested parties in his office March 4, 2013. HB 4354 was raised – the unanimous opinion was – no more "tort reform". Everyone acknowledges that the ER Immunity Bill is not good law or policy. They appreciate that all interested parties less than 12 months ago negotiated in "good faith" regarding this bill and four others and all agreed SB 1110 was bad law and should not, and would not, be pursued. Surely, for any of the interested parties to now support this bill would cast a long shadow over their credibility.

The Questions and the Answers – ER Immunity

***Question*: Is there a shortage of Michigan physicians, particularly ER physicians?**

Facts: For primary care physicians, Michigan ranks 7th in the nation with 14,397 primary care physicians, trailing only much larger states by population: California, Florida, Illinois, New York, Ohio and Texas.

In total physicians, Michigan ranks 8th nationally with 29,827 total physicians, again after the above larger states, plus Pennsylvania.[17]

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[15] After this incident, 2000 PA 318 amended MCL 691.1407 to preclude a governmental employee from asserting the defense of governmental immunity with respect to medical care provided to a patient. The amended statute applies to causes of action arising on or after October 24, 2000, the effective date of the amendment,

[16] Dama written submission, supra.

[17] http://www.statehealthfacts.org/comparemaptable.jsp?ind=934&cat=8

While some have asserted a dangerous shortage in OB/GYN physicians, Michigan also ranks 7th in the nation.[18]

For practicing ER physicians, Michigan ranks 5th nationally.[19]

Answer: NO.

Question: **Are claims against Michigan ER physicians on the rise?**

Facts: Michigan ER Physicians today are only subject to claims of medical malpractice when there is little question of poor care and the damages are life changing or death. Claims against ER Physicians are at a historic low in Michigan due to the tort reform legislation of 1994.

Medical malpractice filings are at a 30 year low. Between 1986 and 2010, new filings have dropped by 80%. In 1986 there were 3629 new cases filed, and in 2010 there were only 808.[20] The filings in 2011 and 2012 plateaued at the 700 - 800 range.

Three times in the last 35 years Michigan has passed some new malpractice tort reform. Michigan has caps on noneconomic damages,[21] strict requirements for expert witness,[22] several liability if there is any patient fault,[23] and collateral source laws requiring the patient, form any recovery, to reimburse Medicare, Medicare, or the private insurer who paid the medical bills caused by the negligent care.[24] These changes have reduced the ultimate recover substantially.

The effect of these laws is that one cannot file a meritorious case unless the damages are substantial, usually greater than $450,000, as the cost of litigation off set against the potential recovery makes the risk of litigation a bad business decision. Cases filings are not down by 80% because these cases do not have merit, but because the law has effectively given the care givers "De Facto Economic Immunity."

There is no litigation crisis for ER Physicians. They are defendants far less than the average of all specialist and, if there is an indemnity payment, it is near the bottom when compared with the other specialties. In 2011, the Department of Medicine at

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[18] http://www.statehealthfacts.org/comparemaptable.jsp?ind=433&cat=8
[19] http://www.statehealthfacts.org/comparemaptable.jsp?ind=933&cat=8
[20] T Berg, *Michigan Lawyers Weekly*, July 7, 2007.
http://courts.michigan.gov/scao/resources/publications/reports/summaries.htm#cir click "statewide" filings. Medical malpractice is coded NH.
[21] MCL 600.1483, Eff. April 1, 1994.
[22] MCL 600.2169, Eff. April 1, 1994.
[23] MCL 600.6304(6), Eff. April 1, 1994. If a governmental hospital or medical care facility, several liability applies in all cases. MCL 600.6304(7).
[24] MCL 600.6303, Eff. Oct 1, 1986.

Massachusetts General Hospital, the Harvard Medical School, and a number of other nationally known groups studied the risk of being sued per physician specialty.[25] When ranked for risk of being sued, based on prior claims, ER Physicians were in the bottom half, 15th on a list of 25.

Answer: NO

Question: **Are indemnity payments for ER claims on the rise?**

Facts: Between 1991 and 2006 indemnity payments fell 59%. The only thing that went up during this same time was the cost of defense, malpractice premiums and insurance company profits. Defense costs rose 109%.[26] More cases are being tried as the defendant's losses are "capped". Caps on noneconomic injuries encourage defendants to gamble in the courtroom; even if they lose, the judge takes away any award over the caps.

Michigan ranks 7th in the nation for the lowest average settlement per injury at $181,198; the national average is $334,559. Michigan's patients and/or their families receive less than half the national average for their injuries. Is this too high?[27]

When one looks at ER at claims actually paid nationally, ER Physicians were far down the list, 18th on a list of 23. Even the low risk specialties of Family Practice, Ophthalmology and Gastroenterology had greater payout than ER Physicians.[28]

Answer: NO.

Question: **Does immunity from responsibility for personal conduct save money?**

Facts: Immunity from responsibility is a huge tax on Michigan Citizens.

A good recent example of "the bills don't go away if there is no lawsuit, but are just passed on" is the dismissal of the Michigan Attorney General's action to collect $20 million from Merck for Medicaid payments for Vioxx.[29] In 1996, Michigan gave drug companies immunity for the production and selling of defective drugs. In 2008, the

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[25] J Anupam, S Seabury, "Malpractice Risk According to Physician Specialty" *N Engl J Med* 2011;365:629 -36.

[26] T Berg, "Different Directions: Medical-Malpractice Reform Promised Lower Insurance Rates for Doctors, Yet as filings Dropped, Premiums Continued to Rise, So Did Insurer Profits," *Michigan Medical Law Report, Legal News for the Medical Community*, Fall 2007, Vol.3, No.3, 1 and 16-17.

[27] Kaiser Family Foundation, State Health Facts. http://www.statehealthfacts.org/comparemaptable.jsp?ind=437&cat=8&sort=a&gsa=2

[28] Anupam, supra.

[29] *Attorney General, State of Michigan v Merck*, 490 Mich. 878, 803 N.W.2d 696, Mich., September 30, 2011 (NO. 142989).

Michigan AG, Michael Cox, sued under the Medicare False Claims Act for fraud based on misrepresentations of efficacy and safety and asked Merck to reimbursement the State of Michigan for Medicaid payments made between 1999 and 2004. In March 2011, the case was dismissed based on Michigan's immunity statute, MCL 600.2946.

One case of immunity cost Michigan taxpayers $20 million.

Between 1986 and 2010, new filings have dropped by 80%. In 1986 there were 3629 new cases filed, and in 2010 there were only 808.[30] The filing numbers have been in the 700 – 800 range since 2007. Between 1991 and 2006 indemnity payments fell 59%. The only thing that went up during this same time was the cost of defense, malpractice premiums and insurance company profits. Defense costs rose 109%.[31] More cases are being tried as the defendant's losses are "capped". Caps on noneconomic injuries encourages defendants to gamble in the courtroom; even if they lose, the judge takes away any award over the caps. The post tort reform net savings in 2006, after eliminating 75% of patient's cases, was about $17 million.[32] This minor savings was lost when Medicare, Medicaid and private insurers lost their subrogation claims for medical bill that would have been reimbursed from negligently injured patient's recoveries.

The unintended consequences of malpractice tort reform is that it saved no money, but cost the system money.

Eliminating lawsuits does not eliminate the medical bills and lost wages – it just shifts the cost to those who did not cause the injury.

Answer: NO.

Question: **Are med mal premiums increasing?**

Facts: Per the latest report of the Michigan Insurance Commissioner at the end of 2009,[33] annual average premium discounts averaged 19.8% for the 5 years of 2003 to 2007, including an average discount in 2007of 24.9%.[34] Mike Reynolds of Pro Assurance verified the above numbers in his testimony before the Senate Insurance

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[30] T Berg, *Michigan Lawyers Weekly*, July 7, 2007. http://courts.michigan.gov/scao/resources/publications/reports/summaries.htm#cir click "statewide" filings. Medical malpractice is coded NH.

[31] T Berg, "Different Directions: Medical-Malpractice Reform Promised Lower Insurance Rates for Doctors, Yet as filings Dropped, Premiums Continued to Rise, So Did Insurer Profits," *Michigan Medical Law Report, Legal News for the Medical Community*, Fall 2007, Vol.3, No.3, 1 and 16-17.

[32] Berg, 16.

[33] Ken Ross, Evaluation of the Michigan Medical Professional Liability Insurance Market, State of Michigan, Office of Financial and Insurance Regulation, October 2009.

[34] Annual average premium discounts are defined as the percentage of how much lower are the actual premiums charged by the insurance carrier relative to the manual rates. Ross, page 27.

Committee on May 22, 2012 and the fact that this trend continues with his company and others in Michigan. [35]

***Answer*:** NO

Question: **<u>If new claims have fallen by 80% and compensation to patients by 60%, have insurance premiums fallen by the same amount?</u>**

***Facts*:** It is tempting to argue that with an 80% drop in filings and a 60% drop in patient compensation that the above referred to premium discounts should be far more than 20%, but that is not the reality of malpractice premium pricings. A concise summary of the reasons behind setting professional insurance premiums is summarized in Richard Boothman's analysis of the state of medical malpractice problems today.[36]

> AIR has consistently found that total payouts have been stable, tracking the rate of medical inflation, but premiums have not. Rather, premiums that doctors pay rise and fall in sync with the state of the economy, reflecting profitability of the insurance industry, including gains or losses experienced by the insurance industry's bond and stock market investments.

People may ask why patient compensation has fallen by more than 60%, but premiums by less than 1/3rd of this number. Contrary to popular belief, there is little to no connection.

Answer: NO

***Question*:** **<u>Will Michigan's patients and families be better protected by ER Immunity?</u>**

***Facts*:** The cost of preventable medical errors per year was $17 billion in 2006 dollars;[37] that figure is estimated to be over $22-25 billion today. The social costs are estimated to be between $393 billion and $958 billion, amounts equivalent to 18 percent and 45 percent of total US health care spending in 2006.[38] When the lawsuits go away, the bills do not – these are still paid by the injured patients, or passed on to the taxpayers through Medicaid, Medicare or higher insurance premiums. MSMS motto of "Patient's First" should be the motto of all of us, but there is absolutely nothing in HB 4354 about

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[35] Mike Reynolds testimony, Senate Insurance Hearing, Lansing, MI. May 22, 2012 transcript page 4.

[36] R. Boothman, A Better Approach to Medical Malpractice Claims? The University of Michigan Experience. *Journal of Health & Life Sciences Law,* (2009) Vol. 2 No 2, 131.

[37] J. Van Den Bos, The $17.1 Billion Problem: The Annual Cost Of Measurable Medical Errors, *Health Affairs*, 30, no.4 (2011):596-603.

[38] J. Goodman, The Social Cost Of Adverse Medical Events, And What We Can Do About It. *Health Affairs*, 30, no.4 (2011):590-595.

protecting patients. This bill is all about insurance profits and eliminating lawsuits against doctors – "Patients Are Dead Last".

Answer: NO

Question: **Are there currently frivolous med mal lawsuits in Michigan?**

Facts: A frivolous lawsuit is one without legal or factual merit.[39] Michigan's laws already prevent any frivolous claims from being filed. Before a lawsuit alleging medical malpractice can be filed, a patient or their attorney must file a Notice of Intent (NOI) that explains precisely what the physician or hospital did wrong and how the patient was injured. This document is often 20 to 40 pages with attachments.[40] Thereafter, when the lawsuit is filed, the complaint must be accompanied with Affidavits of Merit (AOM) signed by specialists of the same qualifications as each defendant certifying that malpractice occurred and caused the patient's injuries or death.[41] Without both of the above, the case is dismissed.

By design, Michigan's 1994 malpractice legislation already prevents many meritorious claims from being filed. Due to the high cost of litigation and limitations on recovery, only cases with egregious negligence and severe injuries can be pursued. An attorney cannot take a case if the potential losses are limited to the lower noneconomic cap – presently $424,800. Defendants try more and more of these cases as their losses are capped. Even if there is a large non-economic verdict, the judge has to reduce this to the current applicable cap before the judgment is entered. If your losses are capped – you can afford to gamble.

For the simplest case, the out of pocket cost an attorney would need to spend to prepare the case for 4 years, and then try it, would be around $100,000. The business analysis is: should I spend and risk $100,000 on a case, work on it for 4 years, and then try it to recovery pennies on the dollar for the client? The market analysis is – bad business decision.

Defendants recognize the economic dilemma of plaintiffs pursuing valid claims with caps on noneconomic damages. What is the reason that Michigan's average payment to settle cases is so far below the national average at $181,198? Attorneys and their clients either take pennies on the dollar to settle their case or try the case with the above risks of losing even more. Trials are up, defense costs are up, payments are down and only the most severely injured with egregious medical care have any legal rights. There are already too many meritorious cases that cannot be filed. "Patients Are Dead Last."

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[39] MCR 2.114(F), MCR 2.625(A)(2), or MCL 600.2591
[40] MCL 600.2912b
[41] MCL 600.2912d.

Answer: NO

Question: **Would HB 4354 effect a limited number of patients and would all patients once admitted be entitled to the same quality of care?**

Facts: A Rand Health study found that hospital emergency rooms are now the point of access for nearly half of all hospital admissions in the U.S. and account for almost all of the growth in admissions between 2003 and 2009.[42] Given that HB 4354 dictates that immunity follows the emergency, half of the hospital patients would have no protection from substandard care. Given the approximately 10,890,000 admissions per year in Michigan,[43] 5,445,500 patients per year would effectively have no recourse if they received substandard care.

The irony and unfairness this would have should be obvious. If there were two patients in the hospital with the same condition, one which came in through the ER and the other that developed after admission while in the hospital, the former would have no recourse for substandard care, the latter would. They could be in the same room, with identical problems, receiving the same treatment, and from the same doctor, but the test for the care received would be worlds apparent:

> Patient A admitted through the ER: The test for care would be "conduct so reckless as to demonstrate a substantial lack of concern for whether an injury results." MCL 691.1407(2)(c)… [or] defendant simply did not care about plaintiff's health and safety."[44]
>
> Patient B, previously admitted, develops same health problem as A: The test for care would be, "the failure to do something which a [physician] of ordinary learning, judgment or skill… would do".[45]

Answer: NO

Question: **Is gross negligence a concept that can be used to test human conduct.**

Facts: Gross negligence has been the flavor of the last decade for state's legislatures, ostensibly looking for a solution between responsibility for one's conduct, but not too much. It's time to give up trying to use this as a compromise for limited responsibility; it

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[42] Study finds jump in hospital ER-related admissions. *Crain's Detroit Business*, May 22, 2013. http://www.crainsdetroit.com/article/20130522/NEWS/130529958/study-finds-jump-in-hospital-er-related-admissions# and The Evolving Role of Emergency Departments in the United States, RAND Health, 2013.

[43] http://kff.org/other/state-indicator/admissions/

[44] *Dama v Dietzel, supra.*

[45] Mich Civil Jury Instruction 30.01 Professional Negligence and/or Malpractice

doesn't work and only results in immunity for careless conduct. The University of Washington Law Review undertook one of the most extensive examinations ever conducted of this concept, spanning 200 years, and concluded it simply does not work as a legal concept in tort law.[46]

> "Recklessness" is one of the oldest concepts in Anglo-American tort law, and it is also one of the most poorly understood. Often identified as a tort falling somewhere between "negligence" and "intentional misconduct," recklessness has evaded precise judicial interpretation for two hundred years.[47]

Their study traced the concept from Homer's Odyssey, through Roman Law (slight, ordinary, and gross negligence) and through England's and America's tort law up to the present Restatement of Tort Law using the now familiar terms of willful, wanton, reckless and gross negligence. The reason it has never worked and won't is the concept, "...is inconsistent with the actual behavioral and cognitive processes humans employ in the face of risk and uncertainty."[48]

While some attempt to dress these efforts to use gross and reckless conduct in terms of societal benefits, all would be better served if they were simply honest. "The financial significance of a finding of recklessness—for both plaintiffs and defendants—is obvious."[49] The goal is to eliminate recovery for injuries suffered from a particular parties' conduct.

While reading this 70 page study and the 461 footnotes paints the historical picture of failed attempts to define a concept that does not work, but only creates more confusion with each new effort, one should not lose sight of why this has not worked for 200 years plus, or from the beginning of all legal systems.

> In other words, while negligence is a valid concept of human decision making, in the sense that a person might unreasonably disregard a risk due to over-optimism, quick decision making or instinct, and while a person can certainly "intend" (in the broad sense of that term) an unfortunate result, the definition of recklessness is at best a set of words that do not accurately describe the way humans think and act.[50]

Answer: NO.

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[46] GC Rapp, The Wreckage of Recklessness, *Un of Wash Law Review*, 2008, Vol. 86:111.
[47] Id. 111
[48] Id.
[49] Id. 116
[50] Id. 120

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Michigan Trial Lawyers Association Seminars (MTLA)

Qualifying the Medical Expert, April, 1980

Cross-Examination of the Medical Expert, October, 1980

Negotiation Techniques in Personal Injury Cases, May 1982

Developing Demonstrative Evidence in a Medical Malpractice Case,

September and October 1983

Structured Settlements, November 1983; June 1984

Cross-Examination of Obstetrical Expert, June 1986

New Michigan Malpractice Legislation, June, 1986

Order of Presentation and Use of Evidence and Witnesses, February 1988

The Present State of Medical Malpractice Law in Michigan
Program Chairman and Moderator; November 30, 1989

Academics and Pragmatics of Medical Malpractice Trial Practice,
Program Chairman and Moderator, November 8, 1990

Advocacy into the 90's, MTLA 46th Annual Convention,
May 16, 1991

The New Medical Malpractice Law Primer, Program Moderator:
Southfield, Michigan, November 5, 1993
Grand Rapids, Michigan, November 19, 1993

Macomb County Chapter, Michigan Trial Lawyers Association,
1994 Medical Malpractice Tort Reform, June 30, 1994

Medical Malpractice Case Development and Trial Practice in the Tort Reform Era.
The Death of Common Sense: Qualifying the Medical Expert in Michigan,
Southfield, Michigan, May 19, 1995

Proving Damages in the 21st Century, Program Moderator:
Novi, Michigan, January 21, 1999

Fast Track Workshop for New Lawyers. *Medical Malpractice:*
Tips to a Strong Positioning of the Case, Southfield, Michigan, March 9, 1999

MTLA 54th Annual Meeting Seminar, Rapid Fire Infusion of New Ideas,
Rights & Remedies: *The Most Important Things You Must Know to Move*
Your Case Toward Settlement, Livonia, Michigan, April 23, 1999

MTLA 55th Annual Meeting, Rapid Fire Seminar: *New Ways to Succeed: Nurses*
and Residents After McDougall; What is the Standard of Care and Who Can
Testify, Livonia, Michigan, April 23, 2000

Medical Malpractice: Affidavits of Merit and Notices of Intent in 2002,
Novi, Michigan, March 22, 2002

Medical Malpractice, Winning in a Hostile Environment. A New Era: On Demand Trial of Experts Before Trial. *Craig v Oakwood,* Davis-Frye, and MCL 600.2955. Novi, Michigan, December 3, 2004

Establishing Qualifications for Expert Opinions Under Davis-Frye, MTLA Annual Rapid Fire Seminar, Dearborn, Michigan, May 13, 2005

Guidelines for Getting into Court and Staying There: Apsey, NOI's, AOM, Waltz. Co-Program Chair and Co-Moderator, Novi, Michigan, October 19, 2005.

Expert Qualifications and Woodard, Michigan Med Mal Law Update, Novi, Michigan, October 6, 2006.

How to Ensure the Insurance Carrier Sets Proper Reserves for Your Client's Claim, 62nd Annual Rapid Fire Seminar, Dearborn, Michigan, May 2007.

Physician Fatigue as a Cause of Medical Errors, MAJ Annual Medical Malpractice Seminar, Novi, MI, November 12, 2009.

How to Settle More Cases for More Money - Secrets to Settling Tough Cases, MAJ Evening Forum, Novi, MI, June 3, 2010.

Preparing Experts for Deposition Cross Examination, MAJ New Lawyers Workshop, Southfield, MI, April 1, 2011

Institute of Continuing Legal Education (ICLE)

Michigan Probate Judges Mid-Winter Seminar: *Structured Settlements*,
Dearborn, Michigan, January 1985

Michigan Tort Reform, Medical Malpractice Statute, Grand Rapids and Southfield, Michigan, September 1986

Motions During Trial, Novi, Michigan, November 1986

Handling Damages in a Personal Injury Case after 1986 Tort Reform
Grand Rapids, Michigan, March 3, 1987; Southfield, Michigan, March 6, 1987

Trial Practice Seminar, The Anatomy of a Lawsuit. 7 weeks once per week, Southfield, Michigan, January through February, 1989

Trial Advocacy Skills Workshop, Ann Arbor, Michigan, January 27-29, 1992

The Art of Cross-Examination, Preparing the Lay and Expert Witness for Cross Examination, Grand Rapids, Michigan, November 4, 1992; Southfield, Michigan, November 9, 1992

Trial Advocacy Skills Workshop, Ann Arbor, Michigan, May 9-11, 1993

Anatomy of a Lawsuit, Voir Dire and the Law of Jury Selection
MSU Education Center, Troy, Michigan, September 26, 1994

Preparing Lay and Expert Witnesses for Cross-Examination
MSU Education Center, Troy, Michigan, December 7, 1995

Everything You Need to Know to Prepare Your Witness for Cross-Examination, Expert Preparation. MSU Education Center, Troy, Michigan, November 3, 2000

Advanced Negotiation and Dispute Resolution, ANDR Institute, A Judge/Practitioner Dialogue Concerning Referral Orders to ADR. Hon. Wayne D. Brazil, US Magistrate Judge; Northern District of California, Oakland, Bruce E. Bigler and Norman D. Tucker. St. Johns Golf and Conference Center, Plymouth, Michigan, March 27, 2003

My Life in the Law, Lessons Learned Along the Way, Deposition Skills Workshop, Luncheon Speaker, St. John Conference Center, Plymouth, Michigan, May 4, 2009.

State Bar, Discussion Panels and Various Presentations

State Bar of Michigan, 51st Annual Meeting, *New Tort Legislation*, Detroit, Michigan, September 1986

Detroit Bar Association Continuing Legal Education,
What Every Lawyer Should Know About Going to Trial,
Detroit, Michigan, March 27, 1987

Michigan State Chamber of Commerce (Leadership Michigan)
Issues in Health Care, Round Table Discussion: The Medical Liability Crisis, Ann Arbor, Michigan, July 1988.
Panelist: Norman D. Tucker;
Robben Fleming, Interim President, University of Michigan;
Dr. Robert E. Paxton, President-Elect Michigan State Medical Society

State Bar of Michigan Young Lawyers Section and Michigan Trial Lawyers, Basic Advocacy Workshop, 46th District Court, Southfield, Michigan, August, 1988

James Tuck Memorial Lecture, *Agenda for Change*,
Eastern Michigan University, December 3, 1988

Medical Malpractice and Patient's Rights; June 2, 1990
Wayne State Law School, Legislative Efforts to Reduce the
Rights of Victims of Medical Malpractice

Medical-Law Workshop One-Day Symposium, *The Brain Damaged Baby ... The OB's Fault?* Southfield, Michigan, May, 1989

University of Michigan Medical Students/Delta Epsilon: Medical Malpractice, *Our Perception is Our Only Reality*,
Ann Arbor, Michigan, April 4, 1990

American Educational Institute, *Pre-Suit Screening of Medical Malpractice Claims* (Tape) June 1, 1990

Michigan Coalition of Aging Organizations, *Medical Liability Claims and Access to Health Care,* Lansing, Michigan, March 19, 1991

Detroit Bar Association, *Improving the Quality of Your Practice*, (tape)
attorney focus group discussion, October 7, 1993
round table discussion, attorneys and clients, October 13, 1993

American College of Osteopathic Obstetricians and Gynecologists,
61st Annual Convention, *Medical Malpractice, the Plaintiff's Perspective and the National Health Security Act*, Scottsdale, Arizona, March 15, 1994

University of Michigan Law School, Henry M. Campbell Moot Court Competition Judge, Ann Arbor, Michigan, November 14, 1994

State Bar of Michigan, Negligence Section, *Tort Reform in Today's Practice*, Moderator, Las Vegas, Nevada, April 18, 1997

Bloomfield Community Cable TV, "Practical Law", Interview/Discussion on Handling Birth Trauma Cases, Bloomfield Hills, Michigan, March 4, 1999

Michigan House of Representatives, Standing Committee on Health Policy, Testimony and Presentation on Strategies to Reduce Frivolous Lawsuits, Lansing, Michigan, April 22, 1999

University of Detroit Mercy, School of Law, combined tort classes of Professors Keenan and Moore, *Michigan Medical Malpractice Law*, Detroit, Michigan, March 12, 2001, and February 3, 2003

Center for Policy Alternatives (Washington, DC), Midwest Policy Leaders Summit. *Organizing for Change: Progressive Solutions and Strategy for the Midwest. Protesting Consumer Rights: Caps on Damages*, Detroit, Michigan, June 29, 2001

The Oakland County Bar Association's "Due Process", WDIV-TV, Channel 4, *Medical Malpractice After Tort Reform*, September 2001

University of Detroit Mercy, School of Law, combined tort classes of Professors Keenan and Moore, *Michigan Medical Malpractice Law*, Detroit, Michigan, March 6, 2002

Ohio Association of Trial Lawyers (OATL) 45th Annual Convention, Medical Negligence Seminar; *Shoulder Dystocia: Using Your Client to Prove Liability*, Columbus, Ohio, April 19, 2002

The Russell W. Bunting Periodontal Study Club, Program Chair and Moderator, *The Trial of a Dental Malpractice Case*, Ann Arbor, Michigan, October 25, 2002

University of Detroit Mercy School of Law, combined tort classes of Professors Keenan and Moore, *Evaluating the Medical Malpractice Case*, Detroit, Michigan, February 3, 2003.

University of Michigan, Program in Society and Medicine, Forum on Health Policy, *We Need Medical Malpractice Reform: Which Approach is Best?* An Expert-Panel Discussion. Moderator, Allen S. Lichter, Dean, U of M Medical School. University of Michigan Hospital, Ann Arbor, MI, November 14, 2003.

Boston University School of Medicine and Center for Human Genetics, *The 20th Annual Conference on Obstetrics, Gynecology, Perinatal Medicine and the Law,* The Fairmont Kea Lani, Maui, Hawaii, January 2-6, 2004.

Presentations:

The Genesis of Shoulder Dystocia and Brachial Plexus Injury Litigation;

Counterintuitive Thought and Language by Physicians in Court; Is Your Lawyer Complying with the Standard of Care?

Legal Commentary to the following medical presentations:

Shoulder Dystocia Management Guidelines that Help Avoid Litigation, Michael A. Belfort M.D., PhD;

Fetal Monitoring by Oximetry-A Developing Standard? Thomas J. Garite, M.D;

The Timing of HIE Injury, Gary D.V. Hankins M.D.;

Pitfalls in Electronic Fetal Monitoring: A Non-Reassuring Pattern, Thomas J. Garite M.D.;

The Pathogenesis of HIE, Gary D.V. Hankins M.D.;

Is Cerebral Palsy Preventable? Evidence, Assertions, Proofs and Facts, Karen B. Nelson M.D.;

Screening vs. Diagnostic Mammography: Guidelines and Standards of Care, Edward A. Sickles M.D.;

Failure to Diagnose and/or Manage a Myocardial Infarction: Deadly Consequences—Medically and Legally, Patrick J. Scanlon M.D.

Trinity Health Insurance & Risk Management Services Perinatal Conference, "Managing Risk in the Obstetrical Arena", *Emerging Issues in Birth Trauma Cases*, Detroit, Michigan, March 1, 2004.

"Good Company" Comcast Cable TV, Host Douglas Kaye. Interview and discussion: *Medical Malpractice: Is There a Medical, Legal or Insurance Crisis*. Dearborn Heights, Michigan, April 27, 2004.

University of Detroit Mercy School of Law combined Tort classes, *The Law and Minefields of Michigan Medical Malpractice*, Detroit, Michigan, April 12, 2005.

Tony Tripiano Progressive Talk Radio, 1310 AM, *The Apsey Decision*, May 18, 2005.

Mercy Hospital Cadillac, 12th Annual OB Conference, November 2-3, 2005, Cadillac, Michigan. One-day presentation (Nov. 3) *"The Two Faces of Obstetrical Litigation, a Plaintiff Attorney's Perspective"* covering the following topics:

Urban Myths of Medical Malpractice. Can we find the solutions if we cannot identify the problems;

Medical Liability Litigation: Understanding the System - the Market Economy's Regulatory and Compensatory goals;

The Law of Medical Malpractice – Ignorance of the law is no excuse – and may be hazardous to your career;

The Plaintiff's Investigation of a Malpractice Claim – what we do and what are we looking for;

Case Examples: *Labor and delivery, Electronic fetal monitoring, Midwifery, Shoulder Dystocia, ER – Triage, Postpartum Hemorrhage, Neonatal;*

Reducing your risk of being a Defendant;

Your Deposition – Cross-examination: what the plaintiffs' attorney is really doing and why.

University of Detroit Mercy School of Law, *What is Driving Tort Reform and Where is it Going.* November 16, 2005, Detroit, Michigan.

Association of Defense Trial Counsel, *The State of Litigation in Michigan*, Royal Oak, Michigan, March 14, 2006.

Michigan House Committee on Tort Reform, *Revisiting the 1994 Medical Malpractice Legislation: Affidavit of Merit and the Notice of Intent to File Suit,* Lansing, Michigan, March 21, 2006.

Medical Malpractice in Michigan, The Law, The Politic and The Practice, The People's Law School, Cooley Law School, Lansing MI, September 30,2008.

American Conference Institute's 8th Annual Advanced Forum on Preventing, Managing and Defending Claims of Obstetric Malpractice, Philadelphia Union League, June 23 & 24, 2009. Presentations: *Resident Fatigue and Medical Error; Does Cool Capping Prevent HIE Injury; Shoulder Dystocia, Old Defenses – New Standard Of Care*

American Conference Institute's 9th Annual Advanced Forum on Preventing, Managing and Defending Claims of Obstetric Malpractice, Philadelphia Union League, June 23 & 24, 2010. Presentations: *Tort Reform Under the March 2010 National Health Care Act - Programs to Evaluate Alternatives to Current Medical Tort Litigation; Effect of Work Hours Fatigue on Safety in OB Practice*

The Politics, The Law, and The Supreme Court: Medical Malpractice in Michigan, The People's Law School, Cooley Law School, Lansing MI, September 15, 2010.

Davis Frye and Daubert, MSU School of Law, Medical Malpractice Class, September 27, 2010, East Lansing, Michigan

Waste in Healthcare Initiative, A Plaintiff's Attorney's Perspective, The Engineering Society of Detroit, ESD Detroit Headquarters, Southfield, MI. April 12-13, 2011.

Physician's Sleep Fatigue as a Major Cause of Medical Mistakes and *Hypothermia Treatment for Asphyxiated Newborns,* American Association of Justice Summer Meeting, Birth Trauma Litigation Group, New York, NY, July 10, 2011

Davis Frye and Daubert, MSU School of Law, Medical Malpractice Class, October 24, 2011, East Lansing, Michigan

New Frontiers in Medical Malpractice Symposium, Early Disclosure and Compensation for Errors versus the Civil Litigation Forum. Moderator: Jonathan Trobe MD. Panel: Richard Boothman, Chief Risk Management Officer University Of

Michigan Health System and Norman D. Tucker. University of Michigan, Kellogg Eye Center, Maimonides Society, March 18, 2012.

American Conference Institute's 11th Annual Advanced Forum on Preventing, Managing and Defending Claims of Obstetric Malpractice, Philadelphia Union League, June 26 & 27, 2012. Presentation: Hypothermia treatment for newborns suffering from acute hypoxic encephalopathy. *Hypothermia: The Legal Implications of a Cool Idea.*

Boston University School of Medicine and Center for Human Genetics, 29th Annual Conference on Obstetrics, Gynecology, Perinatal Medicine, Neonatology and the Law, January 2-6, 2013 Grand Hyatt Resort & Spa, Kauai, Hawaii.

Presentation: *Hypothermia: The Legal Implications of a Cool Idea.*

Legal Forum Presentations:

Obstetricians Embedded in Legal Teams: Trend or True Change?
Apology After an Adverse Event: Has the Time Come?
Jury Trials, Arbitration, or Health Courts: Good for Whom?
Shoulder Dystocia: The New Defense
The Fatigued Obstetrics Resident and the Electronic Fetal Monitor Strip
Legal Implications Following an Expert's Change of Mind

Legal Commentary on the Following Presentations:

Failed Labor Induction by Steve N. Caritis, M.D.

Can Hypothermia Alter Outcome After Hypoxic Ischemic Brain Injury? By Jeffrey M. Perlman, M.B., Ch.B.

Updating Shoulder Dystocia Management to Reduce the Risk of Neonatal Brachial Plexus Injury by Edith D. Gurewitsch, M.D.

The Neurologically Impaired Baby – Science v. Sympathy by James W. Saxton, Esq.

Use and Misuse of Pitocin by Julian T. Parer, M.D., Ph.D.

Newborn Resuscitation: Standards of Expected Care by Jeffrey M. Perlman, M.B., Ch.B.

The Dysmorphic and Hypoxic Infant: Cause or Consequence by Aubrey Milunsky, M.D.

Labor Inhibition Therapy by Steve N. Caritis, M.D.

Vacuum Use and Neonatal/Maternal Morbidity by Julian T. Parer, M.D., Ph.D.

Dynamic Evidence-Based Medicine and Risk Management, Michigan Urological Surgery Improvement Collaborative (MUSIC) 2nd 2013, Tri-Annual Collaborative-Wide Meeting Agenda, May 31, 2013 BCBSM Lyon Meadows Conference Center, New Hudson, MI 48165.

American Conference Institute's 12th Annual Advanced Forum on Preventing, Managing and Defending Claims of Obstetric Malpractice, Philadelphia Union League, June 26 & 27, 2013 Minimizing Exposure to OB Malpractice Litigation: Implementing Preventive Measures, Reducing Risk, and Managing Adverse Outcomes. *The New Tort Reform, A Plaintiff's Attorney's Perspective.*

Michigan Surgical Quality Collaborative Meeting, September 6, 2013 Schoolcraft College VisTa Tech Center, Livonia, MI. Norman D. Tucker and Richard C. Boothman (UMMC) *Dynamic Evidence-Based Medicine and Traditional Medical Malpractice, Is the Intersection Safe?*

Law School and Hospital Seminars and Presentations

Detroit College of Law
American Association of Blood Banks (Institute of Continuing Medical Education, University of Michigan)
Henry Ford Hospital
Providence Hospital
St. Joseph Mercy Hospital
Eaton and Barry County Bar and Medical Association
Michigan League of Nurses Seminar, Mercy College
Inner City in Service Coordinators Association
Deaconess Hospital
Macomb County Nurses Association
Carnegie Institute of Detroit
Macomb County Public Nurses Association
Madison Community Hospital

Professional Affiliations:

American Bar Association
State of Michigan Bar Association
American Trial Lawyers Association
Michigan Trial Lawyers Association
Detroit Bar Association
Oakland County Bar Association
Southfield Bar Association
Trial Lawyers for Public Justice
American Constitutional Society for Law and Policy

Professional Appointments:

State Bar Grievance Panel, Chairman, 1982-1989
Oakland County Mediation Panel
Wayne County Mediation Panel, 1978-1994
Michigan Trial Lawyers Association:
  Chairman Medical Legislation, 1987-1992 and 2003-2006
  Chairman Media Committee, 2004-present
  Executive Board, 1997 to present
  Treasurer, 1997-1998
  Secretary, 1998-1999
  Vice President, 1999-2000
  President-Elect, 2000-2001
  President, 2001-2002
Michigan Governor to the American Trial Lawyers Association, 1990-1991 and 1996-1998
State of Michigan Delegate to American Trial Lawyers Association, 1991-1993
ABA Committee on Law and Medicine,
ABA Tort Reform Task Force on National Health Security Act, 1994
State Bar Negligence Section Council, 2002- present
Chair of Michigan House of Representatives Judiciary Subcommittee on Physician Peer Review, 2002
State Bar Committee on Judicial Qualifications, 2003 - 2009
Michigan Democratic Party, Caucus Review Committee, 2004
Michigan Lawyers Weekly Board of Editors 2006 – 2009
State Bar Business Impact Committee 2009 – 2010
Michigan Association for Justice Medical Malpractice Legislative Committee Chair 2011 – present
Michigan Supreme Court Historical Society – Life Member

Professional Recognitions:

The Best Lawyers in America, Listed Each Edition 1995- present
The Best of the US, Listed Each Edition 2006 - present
Super Lawyers, Listed Each Edition 2006 – present
dbusiness Top Lawyers 2009 –present

America's Most Honored Professionals 2012, awared to top 10% of all recognized professionals in America.

Martindale-Hubbell Rating (AV) Highest Possible Peer Review Rating in Legal Ability & Ethical Standards (1981-present)

Fellow of the Michigan State Bar Foundation, 1992-present

Fellow of the Oakland County Bar Foundation, 1998-present

Michael Franck Award, State Bar of Michigan 2002, Presented to the Attorney Making an Outstanding Contribution to the Profession.

President's Choice Award, from Reginald Turner, 68th President of the State Bar of Michigan, October 16, 2003, for outstanding activities and accomplishments in support of Access to Justice.

Michigan Lawyers Weekly Leaders in the Law 2005. Selected by MLW as an attorney who has distinguished themselves with the Michigan bench and bar.

Respected Advocate Award, The Michigan Defense Trial Counsel annually gives the award to a member of the plaintiffs bar to recognize and honor the individual's history of success in civil litigation, unfailing adherence to the highest standards of ethics and candor in dealing with the court and counsel, and the respect and admiration of counsel on the opposing side of the bar. State Bar Annual Awards Dinner, September 2008.

Best Lawyer of the Year2011, Medical Malpractice, Detroit Area, The 17th Edition of *The Best Lawyers in America* (2011) is based on more than 3.1 million detailed evaluations of lawyers by other lawyers. The lawyers being honored as "Lawyers of the Year" have received particularly high ratings in surveys by earning a high level of respect among their peers for their abilities, professionalism, and integrity.

Michigan Lawyers Weekly Leaders in the Law 2011. Selected by MLW as an attorney who has distinguished themselves with the Michigan bench and bar.

Champion of Justice Award. Michigan Association of Justice (MAJ) Awarded in appreciation for a commitment to the civil justice system and to preserving the rights of citizens. MAJ Annual Dinner, Dearborn MI, May 5, 2012.

The Earl Cline Award for Excellence. State Bar of Michigan Negligence Section awarded in recognition of superb skills, contributions and outstanding achievements in the field of negligence law and dispute resolution. May 17, 2013.

Best Lawyer of the Year2014, Medical Malpractice, Plaintiff's Attorney, Detroit Area. The 20th Edition of *The Best Lawyers in America* (2014). (See info above on Best Lawyer of the Year).

Teaching Affiliations: Adjunct Professor, University of Detroit School of Law, Legal Aspects of Health Care, 1983-2005

Other Affiliations: Board of Directors Michigan National Bank - Oakland, 1985-1986

Publications:

Tucker, Norman, co-author
Handling Birth Trauma Cases, Volume I,
Wiley Law Publications: 1985

Tucker, Norman, co-author
Handling Birth Trauma Cases, Volume II,
Wiley Law Publications: 1989

Journal of Medicine and Law,
Detroit College of Law at Michigan State
University. Commentary Against Caps on Non-Economic Damages (1997): 1:1:121-130.

***News Editorials and/or Articles*:**

Partisanship Invades Supreme Court.
The Detroit News, Op. Ed., October 31, 2000.

An Interesting Species.
MTLA Quarterly President's Page, Summer 2001
(A chronicle of the 1990's tort reform and the efforts on behalf of MTLA advocating for consumer protections).

Who Are We?
MTLA Quarterly President's Page, Fall 2001
(The plaintiff's attorney as an entrepreneur and market force eliminating poor products and services).

Why Don't They Love Us?
MTLA Quarterly President's Page, Winter 2002
(A historical perspective on attitudes towards lawyers and why lawyers should not seek approval, but to promote respect for the law). Republished with permission, Oct/Nov 2004, Trial Talk, Vol. 53, Issue 7, Colorado Trial Lawyers Assoc.; and January 2005, The Advocate, Nevada Trial Lawyers Assoc.

Democracy is Not a Spectator Sport.
MTLA Quarterly President's Page, Summer 2002
(Errors made by spectators in the political arena of democracy).

Warning to the Complacent Frogs: The Pot is Ready to Boil,
Negligence Law Section Quarterly, State Bar of Mich, Winter 2009.

Doctors Drunk with Fatigue: The Cognitive Impairment in Physician's Decision Making After Prolonged Shifts Compared with Blood Alcohol Levels. State Bar of Michigan Negligence Section Newsletter, January 11, 2011.