Can Obamacare Improve Patient Safety? Tort Reform Hasn't.

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The goal of Obamacare is to make healthcare available to everyone. Access and affordability are the keywords that come up in any internet search. Implicit in that promise is "quality" care. Unfortunately, the quest for improved patient safety has been subsumed in the din of partisan bickering. And that, sadly, is dangerous for everyone, as the incidence of avoidable fatal medical errors seems to be going up. Most studies estimate there are at least 400,000 avoidable deaths annually. Some put the total at over one million.

Whether that is the result of more carelessness or more precise measurements is unclear. What is clear is that patient safety has not just taken a backseat to assigning blame for Healthcare.gov's website debacle; it has been relegated to the deep recesses of the healthcare garage.

What follows is the story of how one medical specialty made enormous strides in patient safety, and how another continues to miss its

opportunity. The bigger question is whether Obamacare will foster a culture of quality care in general.
Tom Moore looked to the heavens, whispered a few words to himself, and then turned to me.

"Ten years of heartache, followed by four years of terror."

Moore had just won the second largest jury verdict in a medical malpractice case in New York history: $130 million to a ten-year-old girl brain-damaged during birth.

His joy for the child and her family was evident. The relief Tom Moore felt would come out later. It would wait until after he hugged the family and thanked the jurors.

Four years earlier, on the eve of trial, Tom Moore had turned down an $8 million settlement offer. He then lost at trial.

That he had another chance to try the case was almost unprecedented in the annals of New York law. But the Appellate Court took the very rare step of reversing the first jury's verdict – on the weight of the evidence — and ordering a new trial.

When the $130 million verdict was announced last April, I was sitting in Justice Jerry Garguilo's courtroom in Suffolk County. All around me the defense lawyers in the gallery were decrying a "jury out of control," and how it was a powerful argument for even more tort reform.

But was it?

I spent three months observing the case, reading the transcript, interviewing the jurors and the lawyers, and examining the literature analyzing the impact of 25 years of tort-reform measures. And I came to a very surprising conclusion: medical malpractice lawsuits like this one are very different from the "spilled-coffee" and "loss of psychic powers" cases that fueled headlines of tort abuse in the 1980's and 1990's. Rather, large medical malpractice verdicts may be the strongest drivers in making healthcare safer.

The case Moore had just won, *Reilly v. St. Charles Hospital*, focused on the birth of Shannon Reilly in 2002. She was born with severe cerebral palsy, which was caused by prolonged diminution of oxygen prior to the delivery. That was the only thing both sides agreed on.

It was up to the jury to determine what really happened – and why. Had there been a catastrophic placental abruption – a tearing of the placenta away from the uterus – as the hospital alleged? Or had the nurse failed to notice that the baby's heartbeat had repeatedly slowed over 40 minutes without taking appropriate action?

Today, Shannon Reilly is 11. She cannot walk, speak more than a single word at a time, read, or perform any of the basic tasks of daily living. She can, however, fully understand speech and what is going on around her. She is, as Moore said, "A prisoner in her own body."

Tom Moore is widely regarded as one of the most dramatic and effective litigators in America. His track record of 88 verdicts in excess of $1 million – plus another $1 billion in settlements negotiated for his clients – is unmatched. Jurors recognize his ability and his compassion. As one of the*Reilly* jurors told me, " I really did believe Moore cared for this family and this little girl."

The downside to being a juror on a Tom Moore trial is that he doesn't make it easy. He regularly uses medical terminology and complex sentences. "There were times that I didn't know a meaning to a word he used," said a juror. She, like the other three women and two men on the *Reilly* jury, was college-educated.

Moore consciously tries to "elevate the proceedings." The jurors appreciated it. "I tried to maintain a stoic face," said one. "But we couldn't wait to get into the courtroom each day."

Moore's opponent was Peter Kopff. The two lawyers have no lost love for each other. They had opposed each other four times before the *Reilly* case. And as if to underscore their rivalry, Kopff boasts on his firm's homepage that he won "his first trial against the formidable Kramer, Dillof law firm in June 1977. . . " Tom Moore is the senior partner of Kramer Dillof.

The Reilly Case

Over the course of three weeks the jury heard from more than a dozen expert witnesses and saw hundreds of pages of hospital records and school reports. Much of the court testimony and deliberations focused on the fetal heart monitoring strips. They are long ribbons of graph paper that recorded the baby's heart rate while she was still in the womb.

The fetal heart monitor was attached to the mother, Danni Reilly, as she half-reclined in the delivery room. Danni was a 36-year old nurse who had given birth to a healthy daughter five years earlier at the same hospital. Just before 8PM, the obstetrician, Dr. Jerry Ninia, examined Danni, and pronounced that she was fully dilated. He told her that she should relax for 25 minutes. Then she could start pushing. Dr. Ninia left the room, with Danni in the care of a nurse, while Danni's husband Frank stood by her bedside.

The fetal heart monitor continued to track the baby's heartbeat, recording it on continuous graph paper. The first issue that the jury had to address was what the fetal strips actually showed during a critical 45 minute period. That timeframe was from when Dr. Ninia left the room, until alarms went off and the nurse went running out of the room to find him. Was the heart rate essentially normal as the hospital insisted? Or did the strips show repeated, prolonged decelerations? Because if they did, then there was a specific protocol the nurse was required to follow in order to ensure the baby's safety.

It was those protocols – clearly written rules promulgated by the hospital and part of the obstetric team's training – that Moore argued were not followed. To help make his point, Moore repeatedly projected a blow-up of the rules throughout the trial.

The defense argued that there was no need to trigger the protocols for at least three reasons. First, ACOG — the American College of Obstetricians and Gynecologists, the profession's leading regulatory body – hadn't promulgated or fully subscribed to heart-rate standards that would indicate fetal distress. Second, Dr. Ninia used a three-minute standard –not a two-minute standard that the professional literature said was appropriate – and that was OK. And third, the strips themselves were ambiguous and subject to a professional judgment call by the nurse in the room.
One of the first things the jury did when they finally retired to deliberate about the case was look at the strips. "We looked very carefully at the fetal heart strips, going back several hours and examined them against the hospital notes," said one juror. "Looking at them up-close, being able to see the beginning stages of labor, and then seeing how the fetal heart rate digressed. There was no ambiguity."

Once the jury had determined that the baby's heart had been repeatedly slowing, there was little question whether the nurse should have

implemented the protocols. "For me it was also about the hospital rules," said another juror. "Even I know that rules are written for a purpose. And when they are not followed, and bad things happen, there are consequences."

For the Reilly jury, this was the key piece of evidence. Yet t he jury never knew that the defendants had, for years, repeatedly denied that there were written rules. It was only through the discovery process in a different case — against the same hospital — that Moore happened to find buried deep in the records.

The jury also never knew that in the first trial, Dr. Ninia kept denying the existence of the fetal heart monitor tracing rules. Only when confronted with a copy – the copy Moore would repeatedly put up on a large screen in front of these jurors– did Ninia begrudgingly admit they were in effect at the time of Shannon's birth.

Most of the testimony in any medical malpractice case – and the Reilly trial was no exception — comes from expert witnesses. During deliberations, jurors typically assess the credibility of each witness before weighing what the witness actually said on the stand.

The jury foreperson in the Reilly case explained, "At the beginning of deliberations, I suggested we go around the table, juror by juror, giving our honest opinion and our view of the case." Before we even got into the evidence. When we each described who we believed and who we didn't, there was surprising

agreement."

One of the experts put on by the defense was Dr. Jonathan Davis, a neonatologist from Boston. He was, essentially, the defense's cleanup batter.

When an expert witness takes the stand, it is a common tactic of lawyers on both sides to ask the witness how much he is getting paid for his testimony. (The going rate appeared to be about $500 per hour.) At one point during Moore's cross-examination of Dr. Davis, Moore caught him in an apparent fabrication and contradiction. Tempers flared and the judge called for a short recess.

"The least credible witness in the whole trial was Davis," said a juror. "He got on the stand to defend what the hospital did, or actually didn't do. Moore just ripped him apart in cross-examination, and by the end Davis had no credibility left.. I understand doctors wanting to defend other doctors. But this was just not right. They shouldn't do that."
By the end of the first day of deliberations, the jury had agreed that the hospital had breached its duty of care to the baby and pregnant mother. The question of damages would wait until the next day.

One of the jurors told me that before the jury reconvened to consider damages, he thought to himself, "I'm pretty conservative. I think suing over spilled coffee is crazy and destructive. But that wasn't what happened here. The hospital had rules, didn't follow them, and really screwed up. Money will never make that child whole again.

But she needs care, she needs therapies."
Ironically, he still thinks of himself as a supporter of tort reform.

The Promise of Tort Reform

Tort reform, which began in California during Ronald Reagan's tenure as governor, was intended to accomplish three worthwhile objectives:

- Reduce the number of frivolous lawsuits.
- Enhance the quality of healthcare while controlling costs.
- Halt the tendency of doctors to abandon the practice of medicine; and lower their malpractice insurance costs.

Sadly, very few of these worthwhile objectives have come to pass. There was one notable exception that involved anesthesiologists and their patients. But ironically, the benefits were not the result of tort reform; they were the result of an increase in lawsuits and verdicts against the doctors. More on that later.

Since the early 1980's more than half the states have implemented some form of tort reform. Even "trial-lawyer friendly" New York has reduced the compensation lawyers can receive on malpractice contingency cases. It is now just 10% on medical malpractice verdicts above $1.25 million – a huge cut from the traditional one-third. And of course, if a lawyer loses, he receives nothing.

The Truth About "Frivolous" Lawsuits

Shouldn't caps on pain and suffering, and slashing attorneys' fees have reduced the number of frivolous cases being brought? Perhaps, but only if there were a surfeit of such cases. Surprisingly, there is very little evidence that such a surfeit exists – at least in the area of medical malpractice.

"'Frivolous' malpractice suits are less common than the politicians espousing them," says Jock Hoffman, an executive at CRICO, the insurer and risk management firm serving the Harvard medical community for the past 30 years. "Plaintiffs whose claims lack the fundamental legal components are challenged to find an attorney willing to devote time and out-of-pocket resources, unlikely to find a tolerant court, and even less likely to receive compensation."

Doctors and hospitals win approximately 11% of all med-mal lawsuits filed. Another 46% of the cases are dropped by the plaintiffs before trial. Does this suggest an abundance of frivolous cases? Hardly.

Ironically, one of the tort reformers' key successes has resulted in more doctors getting sued, not fewer. At the tort reformers' urging, many state legislatures have shortened the statute of limitations: the time a plaintiff has to bring a case. Very often, the clock runs out before a patient even discovers he or she is the victim of malpractice.

In response, and as a way to stop the clock and preserve their rights, plaintiffs often include every conceivably liable doctor in the initial suit. But after more thorough investigation and discovery,

plaintiffs recognize that many named parties did nothing wrong — and they drop the suit. In the meantime, the named doctors suffer the indignity and anxiety of having been included as defendants.

While some 57% of all malpractice cases end favorably for doctors and hospitals, the results for plaintiffs are far from a windfall. The 6% of cases that result in a jury verdict for the injured party lead to an average award of $800,000. The remaining 37% that are settled generate a payment to the plaintiff averaging $462,000. And both attorney's fees and expert-witness expenses must be deducted from the payout. Overall, the cost of defending malpractice claims and compensating victims in 2009 was $6.6 billion. And while not small, it is negligible as a percentage of overall healthcare costs: just 0.3% of the $2.5 trillion spent on healthcare that year.

Settlement was a possibility in the Reilly case. Several weeks before the start of the initial trial in 2009, attorneys for the defendants approached Moore, seeking to settle the case. They offered the family $8 million.

Moore discussed it with the Reillys, and they concluded it was not enough to pay for the care and therapies Shannon needed. She was enrolled in a special education school, but had to forgo many academic classes for the speech and occupational therapy sessions. Ideally, Shannon would have attended classes full time and dealt with therapy after school—something both her

family and her principal favored. But, that would cost more than the Reillys could afford, as such an arrangement was not covered by their insurance, or by any government programs.

So Moore countered with a proposed settlement of $16 million. The defense refused, never suggested a compromise figure, and the case proceeded to trial.

The Shocking Frequency of Medical Error

Perhaps the most startling statistic may be just how few medical malpractice suits are actually filed every year. Most experts agree that the number has held steady at about 85,000 annually for many years. In the abstract, that number may seem huge. But when compared to the number of avoidable deaths occurring in our hospitals every year, it is a shockingly small percentage of the legitimate cases that could be filed.

Between 1984 and 2011 there were four major studies of medical errors. Each study was run by doctors, and each methodology was rigorous. The results were eye-opening: each successive study found more and more evidence of widespread medical error. The most highly-quoted study was conducted by the Institute of Medicine at the U.S. National Academy of Sciences. Its report,*To Err is Human,* found that avoidable medical errors — just in hospitals and not including doctors' offices — killed as many as 98,000 people annually. That was more than automobile and workplace accidents combined. They also estimated that another

300,000 people were injured each year. By 2011, a study in *HealthAffairs* estimated the number avoidable deaths was probably closer to one million.
So, in perspective, 85,000 medical malpractice lawsuits seem shockingly low.

On the second day of deliberations, the Reilly jury addressed damages. In such cases, juries weigh two types of damages. The first are economic: medical care, therapies, equipment such as a minivan able to handle Shannon's wheelchair. The second are non-economic: essentially pain and suffering.

"We all agreed," said a juror, "this was a terrible mistake, and Shannon needed to get the help she needs." Another added, "We thought the estimates by Moore's expert witnesses of future medical costs were too low. We know what healthcare costs us. And yet the defense attacked them."

"The toughest issue was life expectancy," volunteered one juror, "and our biggest debate."

The plaintiffs were arguing that Shannon would have a normal life expectancy – 70 more years. The defense said she wouldn't live another 20.

"Shannon has every right to try to live longer," said another juror. "There was no way we were going to say she was condemned to live to just 30 as the defense suggested."

In the end, the jury agreed that Shannon would live for another 55 years, and the economic damages totaled $37 million.

The Cost of "Defensive" Medicine

The tort reformers' second goal was to reduce healthcare costs. Sadly, no one argues that healthcare costs have been appreciably contained – much less reversed — in the 25 years since tort reform measures have been in place.

How much of the $2.5 trillion currently spent on healthcare annually is the result of "defensive medicine" – the unnecessary, redundant procedures that tort reformers rail about? In its most recent report on the drivers affecting healthcare costs – and what can be done to control those costs – the Kaiser Family Foundation never used the words "defensive medicine," "tort reform," or "medical malpractice lawsuits." They simply were not serious factors in driving or reducing costs.

More significantly, both the Congressional Budget Office (CBO) and the Government Accountability Office (GAO) concluded that tort reform has had no impact on "defensive medicine" or healthcare costs. Not only were the claimed benefits non-existent and purely hypothetical, the theory was highly suspect.

Both the CBO and GAO have come to the same conclusion: "defensive" medicine is widely practiced by doctors not out of malpractice concerns, but because doing so generates extra

income for them. The Congressional Budget Office put it succinctly: "So-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by positive (albeit small) benefits to patients."

"The more tests doctors order – even if they are marginally necessary – the more doctors earn," said a doctor in New York who requested anonymity. "We have to make a living, and it is getting tougher and tougher to do so. Both Medicare and private insurance companies are reimbursing us less and less for every procedure we perform. These are not 'unnecessary' tests, and they are certainly not harmful. I have no compunctions about ordering them and billing for them. It is part of the business."

During the Reilly deliberations, the jury conscientiously – almost obsessively – tried to reconcile the monitoring and lab results with the experts' testimony. "We spent much of that first day looking for holes in the plaintiff's case," said a juror. "Jeff [another juror] was a former mechanical engineer, and he loved getting into the details. For example, Dr. Davis [a defense witness] had claimed that Mrs. Reilly had lost a half-gallon of blood. But Dr. Ninia testified, and the hospital records showed it was only 800 cc's. Jeff loved finding those discrepancies.. And when he did, Davis's credibility diminished even more, if that's possible."

The Myth of Doctors Fleeing the Profession

Starting in the mid-1980's and continuing for about 20 years, politicians (mostly conservatives,) generated headlines with the cry that doctors were fleeing the profession. The reason was that nuisance suits and malpractice insurance rates were driving them out of business. (Today, ironically, the headlines are similar but the purported culprit is Obamacare.)

The source of this claim was a 1986 ad from the Insurance Information Institute. Showing a photograph of a woman holding a baby, the headline read: "The Lawsuit Crisis is Bad for Babies." The copy read, "A medical survey shows one out of every nine obstetricians in America has stopped delivering babies. Expectant mothers have had to find new doctors. In some rural areas, women have had to travel elsewhere to give birth. How did this happen? It's part of the lawsuit crisis"

There was, however, no hard data to support these claims. There were, instead, anecdotes publicized by the American Medical Association. And the anecdotes didn't jibe with other facts being put out by AMA: the number of doctors was increasing – at more than twice the growth rate of the U.S. population.

According to Professor Tom Baker of the University of Pennsylvania Law School, and the author of *The Medical Malpractice Myth*, the charge of "doctors fleeing the profession" is completely anecdotal. "Not one of the five major studies designed to rigorously track and analyze this claim have found any evidence to support the claim."

In the Reilly case, there was one episode of a health professional "fleeing" the state. Some time after her deposition in the case, Amber Piccione, the nurse who had been in the delivery room with Danni Reilly, moved to North Carolina. Insurance premiums had nothing to do with her decision; her availability to testify in the trial might have. As an employee of the hospital, the hospital was vicariously liable for any errors the nurse might have made. And her testimony – the only eyewitness account (other than the parents) – could have important implications in the trial. Because she was not a named defendant in the case, the plaintiff could not subpoena her to testify. She could, of course, voluntarily return to the state – had she believed her testimony important to vindicate her former employer. But she never did.

Although the jurors initially wondered why she wasn't present for the trial, it didn't weigh heavily in their deliberations. "Under Moore's cross-examination, Dr. Ninia finally admitted that the nurse should have informed him of the decelerating heartbeat," said one juror. "Dr. Ninia's testimony was key for most of us."
The jurors did wonder why Dr. Ninia wasn't a defendant in the case. They knew he had been a defendant in the first trial, but not why he wasn't a defendant in this trial. "When Kopff called Dr. Roberts [an expert witness] to defend the hospital, she tried. But she really ended up throwing Ninia under the bus," said a juror.

The jury did not know the details of the incredible roller-coaster path the case had taken through the legal system. The Reilly case was first tried before a jury in 2009. As the trial progressed, Tom Moore became increasingly confident that there would be a verdict in favor of his client. Then, unexpectedly, one of the jurors said she could not continue serving any longer. She was replaced by an alternate chosen "out of the wheel" – a revolving drum that included the names of the four alternate jurors.

When the case finally went to the jury, the unimaginable happened: the jury voted for the defendants. Moore was shocked, "I cannot explain it. There was no rational way the jury could have voted that way. I can only believe that the deliberations got hijacked by the newly-promoted alternate."

The losing side in almost every trial has the right to appeal the verdict. The odds, however, are very long for plaintiffs in medical malpractice cases. Appellate courts are very reluctant to reverse a decision where a jury has found in favor of doctors and hospitals.

Nevertheless, Moore appealed the jury verdict from that first trial.

During the oral argument before the Appellate Court, one of judges asked the defense why Nurse Piccione had not testified at trial. The defense said that the nurse was in the final stages of Parkinson's disease.

That surprised Tom Moore. He dispatched a private detective to North Carolina. It took several months, but the detective returned with video showing Nurse Piccione. Far from being in the final stages of Parkinson's disease, she was making daily trips to her health club and working the night-shift at a local hospital. The Appellate judges never heard about Nurse Piccione's true condition.

In a rare decision, the Appellate court reversed solely on the "weight of the evidence." (The vast majority of reversals are because of erroneous rulings by the trial judge.) Here, the Court essentially ruled that there was no way a jury could fairly come to the conclusion they did based on the evidence presented at trial. The Appellate Division ordered a new trial.

The jury in the final trial never knew about the defense's sordid behavior concerning the alleged reason for Nurse Piccione's absence.

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Malpractice Insurance Costs

As the tort reformers have long claimed, the cost of medical malpractice insurance can be sizable, depending upon the specialty and geography. An Ob/Gyn in a New York City suburb paid about $178,000 in premiums in 2009. (An upstate-New York Ob/Gyn paid only about $50,000.) It is estimated that insurance premiums account for about 7% of a medical office's operating expenses.

In 2011, the Robert Wood Johnson Foundation analyzed 11 major studies on the impact of tort reforms on malpractice insurance rates. They found that despite dramatic caps on pain-and-suffering awards, much lower fees for lawyers, and barriers designed to keep cases from ever reaching the courthouse steps, insurance premiums still increased in tort reform states. In fact, they went up almost as much as in non-tort-reform states, trailing by only 6% to 13%.

The Anesthesiologists' Story

One medical specialty has experienced huge reductions in malpractice insurance premium costs: anesthesiology. The savings, however, had absolutely nothing to do with tort reform. Instead, they were the result of anesthesiologists tiring of being sued and losing huge verdicts. One of the lawyers winning those big cases was Tom Moore.

In the 1970's and 1980's, anesthesiologists were paying some of the highest medical malpractice insurance premiums in the country. Problems were frequent, serious, and directly attributable to anesthesia. It was estimated that 1 in 6,000 administrations of anesthesia resulted in death; and serious brain injuries were even more frequent.

In 1982 the situation for the anesthesiologists became untenable. ABC News broadcast a documentary entitled "The Deep Sleep, 6,000 Will Die or Suffer Brain Damage. " Media and public reaction was devastating. The anesthesiologists decided they had to do something.

Within months, the American Society of Anesthesiologists initiated a comprehensive assessment of what had been injuring patients. They soon determined that human errors had caused an extremely large percentage of anesthesia-related injuries.

The anesthesiologists decided to act – decisively. They developed a set of mandatory anesthesia patient monitoring standards. They redesigned their procedures, established mandatory monitoring standards, improved training, limited the number of hours doctors could work without rest, redesigned machines, outfitted others with safety devices, developed new tools, and insisted on their use. The anesthesiologists aggressively sought to reduce the total number of errors, and to minimize the consequences of any errors that did occur. In short, they sought to systematically make the practice of anesthesiology as safe as it could be for patients

It all worked. Within 10 years the mortality rate had dropped from one in 6,000 to one in 200,000 administrations. And as a side-benefit to the doctors, their malpractice insurance rates dropped from among the highest of any specialty to among the lowest.

The Anesthesiologists vs. the Obstetricians

"Compare what the anesthesiologists did with what the obstetricians fail to do," said Tom Moore. "Read the study by the three doctors from New York Presbyterian, and then ask ACOG [the American College of Obstetrics and Gynecology]

how many of the patient safety initiatives they've adopted."

The study Moore was referring to was published in 2011 in the American Journal of Obstetrics & Gynecology. The three authors, senior doctors at the hospital and its Weill-Cornell Medical School, developed an interdisciplinary program to improve maternal and newborn safety. They implemented the new program over 7 years, and tracked the impact on what are called "sentinel events" — unanticipated events that result in death or serious injury to patients.

Between 2002 and 2009, the hospital instituted 21 different changes. They ranged from better communication among the medical team members to limiting the use of certain medications. (Several medications were very popular among obstetricians but risky.) Some reforms were simple. For example, they color-coded certain medication containers that were particularly dangerous when used near women in labor. Others involved technology, such as implementing electronic medical records.

The results were breathtaking. Sentinel events dropped from 1.04 per 1000 deliveries in 2000 to zero in 2008 and 2009. To put that into perspective, in 2003 the hospital and its doctors paid victims of sentinel events more than $50 million in compensation. In 2009, they paid $250,000 — a remnant of a malpractice case that predated the reforms.

The authors concluded that the best way to avoid losses due to malpractice was to reduce adverse outcomes.

I contacted ACOG and asked them whether they had formally adopted the NY Presbyterian reforms, and if they had they promoted them to doctors and hospitals across the nation. ACOG e-mailed me, saying it was all "for quality healthcare for women…and most of the initiatives" — except when they weren't. There were "variations… limitations…that may not be feasible or appropriate…and subject to the critical assessment of the individual institution."

ACOG's response didn't surprise Steve Pegalis. Pegalis is a successful med-mal plaintiff's attorney – and my former law school professor. He has spent 20 years trying to foster a dialogue between physicians and attorneys in the hope of improving patient safety.

"ACOG is a political organization pretending to be an educational organization," says Pegalis. "Over ten years they've appointed two major committees to address the related problems of sentinel events and costly lawsuits. And twice the committee has come back with recommendations that were purposefully ambiguous. They were designed to aid in the defense of lawsuits, not help doctors identify dangerous situations during childbirth."

It wasn't only lawyers who complained about the purposefully ambiguous recommendations. One of the ACOG committee members was so frustrated she spoke to the press. NIH scientist

and author Dr. Karin Nelson – the acting head of the National Institute of Neurological Disorders and Stroke – told a reporter from the Philadelphia Inquirer, "It is intended for litigation."

The last question the Reilly jury had to address was by far the most controversial: how much did Shannon deserve to be compensated for the pain and suffering she had endured – and would yet endure?

"We all agreed that this had been a terrible mistake, and that they had to pay to ensure that Shannon gets the help she needs. We didn't want to be vindictive towards the hospital, but there really was pain and suffering," said a juror.

It became more understandable when Shannon's 16-year old sister Ryan testified. "Shannon was in the courtroom that day," said a juror. "The sister explained how she and her friends tried to include Shannon in their activities, even taking her to the mall. When she talked about how she deals with people staring at Shannon and not knowing how to act around her, and just wanting to protect her sister, it was very moving. I looked at Shannon, sitting there in her wheelchair, trying to control her head. The sister helped me understand what it was like to be Shannon. You could see it: she was aware, she understood. The sister brought it alive."

"So why did you award so much?" I pushed.

"I would have given less," the juror explained. "But then someone repeated Moore's phrase – she's a prisoner in her own body

"We knew it was a lot of money. Then one person remembered something Kopff [the hospital's lawyer] had said in his closing. Kopff was ridiculing Moore about something. Oh, I remember: he was saying Moore could have sued the nurse; it's not uncommon to sue a nurse. But then you have a nurse sitting there and you're asking for $100 million; and the jury might have sympathy for the nurse. We suddenly realized that it was Kopff who had brought up $100 million. Kopff made it OK for us to give a big award for pain and suffering. He legitimized it."

The jury gave Shannon $10 million for her past pain and suffering; and another $82.5 million for future pain and suffering.

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The case is still not over. The defense has asked the court to set aside the verdict – or at least reduce it. Peter Kopff is convinced that the trial judge, Justice Jerry Garguilo, is required to reduce the verdict to no more than $6 million. "The Appellate court has set parameters on how much this sort of case is worth," said Kopff.

I asked Peter Kopff, why the case wasn't settled in 2009. "If Moore had come down, we would have come up."

And if the judge doesn't reduce the verdict? I asked.

“We’ll appeal,” said Kopff.

Tom Moore was not surprised. That strategy has been “painfully evident throughout the 11 years of the Reilly case,” said Moore. “The saddest part, of course, is that Shannon’s injuries were avoidable.

“But the most infuriating part is that they knew they were in the wrong years ago. They knew it (A) when it first happened. They knew it (B) when they first offered $8 million to settle the case. And they knew it (C) between the first and third trials when they never offered this victim a dime. And they still won’t end it. “

The anger on Moore’s face suddenly changed to sadness as he paused, then continued. “They won’t allow this poor child get the therapies she so desperately needs. She could have been getting help all this time, making even more progress. “

He paused once more, and this time the frustration was evident. “But instead they’ve chosen to defend the indefensible; and they’ve probably spent millions doing so. Those millions, plus the $8 million offered in 2009 might well have brought this whole matter to an end long before.”

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What message does a $130 million verdict send? And how will it be received by the different parties? The Reilly jurors told me repeatedly that they were only trying to do what was right for Shannon. They took great care not to be vindictive, and they weren’t trying to “send a message.”

It would be easy for the hospital, its lawyers, and ACOG to simply decry it as another jury "out of control." But what would it take for them to shift their perspective, to say, "This was an inherently conservative, well-educated jury that was clearly outraged. Why? And what should we do about it?"

The conventional wisdom might be to hunker down, to pursue the traditional insurance industry strategy of delay, deny, and defend. An alternative approach might be to do what the anesthesiologists did back in 1983, and say "Enough!"

What will it take to get ACOG to shift from a purposefully ambiguous mindset to one that is centered on patient safety? It took a lot of bad publicity to convince the anesthesiologists to make that shift. Perhaps this article will be the first rumblings of an avalanche that will lead to greater patient safety in obstetrics.