INNOVATIVE SOLUTIONS TO MEDICAL LIABILITY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

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INNOVATIVE SOLUTIONS TO MEDICAL LIABILITY

THURSDAY, JULY 13, 2006

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:09 a.m., in Room 2123 of the Rayburn House Office Building, Hon. Nathan Deal (Chairman) presiding.

Members present: Representatives Deal, Norwood, Shimkus, Shadegg, Pitts, Ferguson, Burgess, Barton (ex officio), Pallone, Gordon, Eshoo, Green, DeGette, and Capps.

Staff Present: Randy Pate, Counsel; Ryan Long, Counsel; Brandon Clark, Policy Coordinator; Nandan Kenkeremath, Senior Counsel; Chad Grant, Legislative Clerk; John Ford, Minority Counsel; and Jessica McNiece, Minority Research Assistant.

MR. DEAL. The committee will come to order, and the Chair will recognize himself for an opening statement.

I am pleased that today, we have a very distinguished expert panel that is going to testify on the issue of the performance of our current medical liability system. At today's hearing, we are going to hear testimony about the performance of the current system in compensating injured patients and deterring negligent conduct and ensuring access to quality medical care. Additionally, we intend to discuss non-traditional and innovative medical liability reform proposals from some leading experts in the field.

It is becoming increasingly difficult to ignore the fact that our current legal medical liability system is broken. However, needed reform is continually being opposed by those who stand to profit handsomely from the unsustainable status quo. Unfortunately, patients are the ones who stand to be hurt the most by this broken system.

There is no denying the fact that there is a medical liability crisis in this country, and I don't need to repeat the staggering statistics about the astronomical rates of increase and the cost of medical liability insurance over the past few years or talk about the tens of billions of dollars wasted each year to frivolous lawsuits and doctors forced to practice defensive medicine in order for us to recognize that we have a legitimate crisis on our hands that must be addressed as soon as possible.

Coming from a largely rural district in North Georgia, I view this problem primarily as one of access to healthcare. When the only OB/GYN within a 200-mile radius of your home refuses to see you because you are a high-risk patient, there is a problem with the current medical liability system. When you have to be flown to a neighboring State just to receive a common medical procedure that was once available in your own home town, there is a problem with the current medical liability system. When people are dying because their local trauma center was forced to close its doors, there is a problem with the current medical liability system.

Why would any medical student be interested in starting his or her practice in rural Mississippi, where I understand the average physician's salary is only $72,000, if he can expect to pay a $70,000 premium for malpractice? That doesn't sound like a very smart career move, and clearly, I think something has to be done.

I have spent over 23 years in my career as a trial attorney. I have also served as a judge and as chairman of the Judiciary Committee at the Georgia State Senate where I was active in developing legislation to help curb the growing problems in our State's tort system. From this experience, I recognize this problem does not have a single source and there is not a magic bullet or a Band-Aid solution that is going to make it go away. That is why I support an innovative and comprehensive solution to this problem. I am looking forward to having a cooperative and productive conversation on this topic today and to working with my colleagues on both sides of the aisle to help come up with an effective legislative solution to this crisis.

In this Congress, like several Congresses before, the House has passed, with my support, H.R. 5, the Health Act, a bill that would provide comprehensive liability protection for providers. However, the narrow Republican Majority in the Senate allowed the Democrats, most of whom are opposed to meaningful medical liability reform, to obstruct the debate through parliamentary tactics, and unfortunately, this Congress is shaping up to be a repeat of the last.

That is why I hope I can work with my colleagues on both sides of the aisle to develop an effective medical liability reform package that can overcome the current legislative stalemate between the House and the Senate and produce meaningful reductions in the number of wasteful and frivolous lawsuits while at the same time advancing the cause of patient care. Everything is on the table and we are open to looking at a variety of different proposals, such as liability protection for doctors who cover indigent patients, provisions that prevent a doctor's own apology to a patient for being used against him in a court of law, and provisions which were incorporated in my home State during this past legislative session.

We will continue to pursue a variety of avenues to enact meaningful medical liability reform. We believe that enacting common sense guidelines for healthcare lawsuits will ensure that injured patients receive greater compensation while at the same time deterring frivolous lawsuits that extort money from healthcare professionals and drive doctors from the practice of medicine.

We will continue to fight for meaningful medical liability reform until the job is done. Our healthcare system needs these reforms. If we are serious about expanding patient access to high-quality healthcare, then we must deliver on this issue.

Again, I would like to thank all of our witnesses for participating today. I look forward to hearing your testimony.

[The prepared statement of Hon. Nathan Deal follows:]

PREPARED STATEMENT OF THE HON. NATHAN DEAL, CHAIRMAN, SUBCOMMITTEE ON HEALTH

- The Committee will come to order, and the Chair recognizes himself for an opening statement.
- I am pleased to say that we have an expert panel of witnesses appearing before us this morning that will help us examine innovative proposals for improving the performance of our medical liability system.
- At today's hearing, we will hear testimony about the performance of our current medical liability system in compensating injured patients, deterring negligent conduct, and ensuring access to quality medical care. Additionally, we intend to discuss non-traditional and innovative medical liability reform proposals from leading experts in the field.
- Without question, it is becoming increasingly difficult to ignore the fact that our current medical liability system is broken. However, needed reform is continually being opposed by those who stand to profit handsomely from this unsustainable status quo.
- Unfortunately, patients are the ones who stand to be hurt the most by this broken system.
- There is no denying the fact there is a medical liability crisis in this country, and I do not need to repeat the staggering statistics about the astronomical rates of increase in the cost of medical liability insurance over the past few years or talk about the tens of billions of dollars wasted each year due to frivolous lawsuits and doctors forced to practice defensive medicine in order for us all to recognize that we have a legitimate crisis on our hands that must be addressed as soon as possible.
- Coming from a largely rural district in North Georgia, I view this problem primarily as one of access to heath care.
- When the only OB/GYN within a two-hundred-mile radius of your home refuses to see you because you are a high-risk patient, there is a problem with the current medical liability system.
- When you have to be flown to a neighboring state just to receive a common medical procedure that was once available in your own hometown, there is a problem with the current medical liability system.
- And when people are dying because their local trauma center was forced to close its doors, there is a problem with the current medical liability system.

- Why would any medical student be interested in starting his or her practice in rural Mississippi where the average annual physician salary is only $72,000, if he or she expects to pay as much as $70,000 per year in malpractice premiums? That doesn't seem like a smart career move to me.
- Clearly, something has to be done.
- I have spent over 23 years of my career as a trial attorney. I have also served as a judge and was the Chairman of the Judiciary Committee in the Georgia State Senate where I was active in developing legislation to help curb the growing problems in our State's tort system.
- From this experience, I recognize this problem does not have a single source and there is not a magic bullet or a Band-Aid solution that will make it go away.
- That is why I support an innovative and comprehensive solution to the medical liability reform crisis in this country.
- I am looking forward to having a cooperative and productive conversation on this topic today and to working with my colleagues on both sides of the aisle to come up with effective legislative solutions to this crisis in our healthcare delivery system.
- This Congress, like several Congresses before, the House has passed, with my strong support, H.R. 5, HEALTH Act, a bill that would provide comprehensive liability protection for providers.
- However, the narrow Republican majority in the Senate allowed the Democrats, most of whom are opposed to meaningful medical liability reform, to obstruct the debate through parliamentary tactics.
- And unfortunately, this Congress is shaping up as a repeat of the last.
- That is why I hope to work with my colleagues on both sides of the aisle to develop an effective medical liability reform package that can overcome the current legislative stalemate between the House and Senate and produce meaningful reductions in the number of wasteful and frivolous lawsuits while at the same time advancing the cause of patient safety.
- Everything is on the table and we are open to looking at a variety of different proposals, such as liability protections for doctors who cover indigent patients and provisions that prevent a doctor's own apology to a patient from being used against him or her in court, which were provisions passed into law in my home state of Georgia this past legislative session.
- We will continue to pursue a variety of avenues to enact meaningful medical liability reform. We believe that enacting common sense guidelines for health care lawsuits will ensure that injured patients receive greater compensation while at the same time deterring frivolous lawsuits that extort money from health care professionals and drive doctors from the practice of medicine.
- We will continue to fight for meaningful medical liability reform until the job is done. Our health care system needs these reforms. If we are serious about expanding patient access to high-quality health care, we must deliver.
- Again, I would like to thank all of our witnesses for participating today, and we look forward to hearing your testimony.
- At this time, I would also like to ask for Unanimous Consent that all Members be allowed to submit statements and questions for the record.
- I now recognize the Ranking Member of the Subcommittee, Mr. Brown from Ohio, for five minutes for his opening statement.

MR. DEAL. At this time I would ask unanimous consent that all members may be allowed to submit statements and questions for the record. Without objection, so ordered.

I am now pleased to recognize, sitting in for my normal ranking member, Ms. DeGette from Colorado, for 5 minutes for her opening statement.

MS. DEGETTE. Thank you very much, Mr. Chairman.

And I, too, am glad that you are holding this hearing called "Innovative Solutions to Medical Liability," and I think we should try to work on this issue in a bipartisan way to solve the very real problem of high insurance rates for doctors around the country leading to gaps in services everywhere.

I am disturbed, though, that while you say that you want to work on this issue in a bipartisan way, you put the blame squarely on the Senate Democrats for stopping legislation. In truth, I have been working on this issue for over 10 years, and I, too, am a reformed trial lawyer. And I think that we could solve this if we could sit down in a bipartisan way. And we passed the legislation through this committee last time, however, I was told by the then-bill sponsor, my good friend, Jim Greenwood, that there would be no amendments to the bill, no compromises to the bill, no topical changes to the bill, and that the interests who had written the bill would allow no amendments. That, to me, does not signal a lead towards a bipartisan solution.

And so, Mr. Chairman, I am glad that you are now our Chairman, and I will look forward to working with you in a meaningful way to truly work on a compromised solution.

I think there are really several issues that we need to look at when we examine the alternatives to solve the malpractice insurance crisis.

The first issue is do these solutions really help solve the perceived or real medical malpractice insurance rate prices. And secondly, do they disproportionately put the burden on the victims of medical malpractice. For example, under the health court plan, which is one of the alternatives we will discuss today, injured patients would be paid according to a pre-determined compensation schedule. That schedule would be determined by a commission appointed by the President and Congress.

Now such a schedule may work for some cases, but it could also essentially cap the damages for other patients, regardless of individual circumstances. And there is one indication that I have seen in the literature that such a proposal would actually reduce insurance rates because it does nothing about the insurance companies.

A second idea is to limit victims' rights to a jury trial. And I have concerns about this, because in our entire civil system, our common law system in the States, juries have always decided with medical malpractice rates and now there are anecdotal stories about juries. For the most part, the studies have showed that the juries have done an excellent job in reaching disputes. And the question would be, are there

other, less draconian results than allowing cases to be decided by a jury of one's peers.

Now, of course, Mr. Chairman, our current system is not perfect, and some of the witnesses here today will talk about a study that Dr. Marilyn Hart did. It concluded that the system is not filled with frivolous lawsuits, and that the cost of the system mainly comes from disputing and compensating claims involving medical mistakes. So it is not the duplicative plaintiffs or the greedy lawyers who are cashing in on a slew of bogus suits, although we do need to work to stop bogus lawsuits. But what we need to try to figure out is how we can minimize medical malpractice and how we can try to make the system work in the best way for everybody. We need to make sure that victims are compensated when they are injured by medical mistakes. We need to have a system where the very small number of doctors who are causing the very great number of errors are punished and the majority of doctors who are performing well are left alone. We need to increase our knowledge of medical errors and make sure that information is shared. And one last point, we need to look at some other creative ways. An insurance company in my State has a three "R" program: recognize, respond, and resolve. And this is a program that encourages doctors to communicate with patients when there is an unintended injury and apologize. And they have found that, and I would love to hear the witnesses talk about this; this minimizes a lot of the lawsuits.

Finally, Mr. Chairman, this hearing is called "Innovative Solutions to Medical Liability." For many years, I have been saying to deaf ears that one of the things we need to look at if we are going to eliminate the high cost of malpractice insurance for doctors is insurance pricing practices and risk costs around the country. If we can do that, Mr. Chairman, I think we can put that as part of our whole package. We can't leave any part of the system out in our deep analysis and our crafting of legislation.

Thank you very much.

MR. DEAL. I thank the gentlelady.

Mr. Shimkus is recognized for an opening statement.

MR. SHIMKUS. Thank you, Mr. Chairman.

I want to welcome the panel here.

I am from Madison County, Illinois. It is pretty famous, and it is famous most recently for going down on the list of court systems. The reason why it has done that is because this debate was taken to the public in our election in which we elected the first Republican Supreme Court judge from the southern part of the State of Illinois, and it has really helped wake people up that not only is this an issue and a concern for doctors, but it is really an issue for access and the patients. But there is still a problem. We have a doctor leaving the metro east area, who is in

the local paper, who practiced 20 years in the area, because of still high medical liability insurance.

So this is an emotional debate for those who are injured, those who want access to the courts, those who want compensation, those who want their local doctors present. And I appreciate the Chairman, because the Chairman does bring a different perspective based upon his background that we are working with. And there are a lot of things that we can do. Because of that election, and that is how public policy sometimes gets changed is things are falling apart, the public revolts, and you get an election that signals to public policy individuals who go change the laws. The State of Illinois changed their law. They did some of the things that my friend Diana DeGette mentioned. It wasn't just judicial reforms. It was medical discipline issues, judicial reform. They raised the $500,000 punitive cap. There were also some issues on insurance. And so it was an expanse of legislation, so I really don't know how it will portray in the years to come, but it has helped the growth of the access of doctors in my area.

So I am open for a good discussion and other ideas. We do have a great court system. Ninety-nine percent of all doctors are great doctors. Ninety-nine percent of the people who serve in the court system, whether they are judges or they are lawyers, are great. We always have a percentage that take advantage, or we have a percentage of bad doctors that cause us problems and we overreact. I think all the public wants is access to their doctors and at an affordable rate by which everyone then can pay for healthcare and folks can have access to care.

So I am looking forward to hearing the discussion. Hopefully we won't get pulled away too much.

And I thank you, Mr. Chairman. I yield back.

MR. DEAL. I thank the gentleman.

Mr. Pallone is recognized for an opening statement.

MR. PALLONE. Thank you, Mr. Chairman.

Medical liability is a very real problem in my home State. Just last year, doctors in New Jersey went on strike to protest the rising costs of malpractice insurance, and since then, I continue to hear from doctors on a near-daily basis. Skyrocketing premiums couched between declining reimbursement rates and increased overhead costs are putting many of them out of business. And I have met physicians who have left their practice in order to sell real estate as well as medical students who are being forced to leave New Jersey once they earn their degrees. So clearly, we have a problem.

Now Mr. Chairman, although this is not the first time the subcommittee has considered this very important topic, we have made very little progress at reaching a solution. Over the years, there has been

little effort on the part of the Republican Majority to reach across the aisle and work with Democrats on a satisfactory solution to medical liability reform. Mostly we just get name-calling, saying the Democrats don't want to address the problem, particularly the Senate Democrats, and in my opinion, everything was done just to move H.R. 5 very quickly through this subcommittee and full committee without paying attention so that it would pass the Senate or without reaching across and trying to come up with solutions that would get a bill passed and signed into law.

And so I am hoping that today's hearing will mark a new beginning for us to finally come together on a bipartisan basis to address this important issue. Now there is some common ground from where we can begin. If we are to address the issue of medical malpractice, we need to talk about improving patient safety. It has been 6 years since the Institute of Medicine issued its landmark report, and yet I am not sure we have made much progress on reducing medical errors. And furthermore, we need to reduce frivolous lawsuits, so surely we can come to an agreement on the best way to accomplish this goal.

But there are areas in which Democrats and Republicans remain divided, and I strongly believe that insurance reform should be included in any discussion of medical liability reform. There are definitely members of this committee who do not believe that a cap, per se, will reduce insurance rates. They want the issue of premiums and insurance rates addressed directly.

The other thing is that Republicans have been inflexible on the level of the cap. Efforts were made in this subcommittee to have a cap that was $500,000 or $1 million, and they were just rejected outright. But what is most important, we have to just address the problem of liability reform for providers. Now H.R. 5, and other similar bills in the past, have not been limited to medical malpractice, and they take in manufacturers, distributors, suppliers of drugs, medical devices. That is not where the problem is right now, and when you throw that in, it is like basically throwing in the kitchen sink. We are not really addressing the problem of providers.

So I hope that today we move beyond the knee-jerk reaction legislation proposed in the past that just was used by the Republicans to bash the Democrats and that Republican leadership knows very well that H.R. 5, in its current form, is not going to pass the Senate. It is not going to be signed into law. We have got to get down to things that actually work. And I hope that today is going to be a beginning of trying to work with us on a bipartisan basis.

Thank you, Mr. Chairman.

MR. DEAL. I thank the gentleman.

Mr. Burgess is recognized for an opening statement.

MR. BURGESS. Thank you, Mr. Chairman.

I, too, want to thank you for having this important hearing.

I do have an opening statement that I will submit for the record, but I do want to take the occasion to acknowledge that, one of the few times on this subcommittee, I am going to agree with the gentlelady from Colorado that the system is not functional.

Ten years ago, as a practicing physician, if someone were to ask me what do you think would work as far as reforming the medical liability or the medical justice system, I probably wouldn't have come up with the idea of caps on non-economic damages. I will tell you that 3 years after my State of Texas has passed a cap on non-economic damages, that is broken into three parts, a part for the doctor, a part for the hospital, a part for a second hospital or nursing home, for a total of $750,000 on non-economic damages, I am a believer. One of the reasons I am a believer is because of the money that has come back into the healthcare system, particularly in not-for-profit hospitals that was really an unintended consequence of passing the cap on non-economic damages.

When we passed our bill here on the House side some 3 years ago, my first year in Congress, the Congressional Budget Office recorded that as a $15 billion savings. I think that is a reasonable place to look for savings as we try to look for additional money to put into our healthcare system. Still, I am willing to listen to other arguments. I am particularly glad to see Dr. Mello here this morning. I think I agree with her that the administrative costs in this system are far too high. I can remember a morning in the mid-1990s when, in a very uncomfortable moment, I retrieved those foreign objects from a patient's abdomen during a laparoscopic surgery. After I got over the self-congratulatory part of being able to get this foreign object out of the abdomen, because it was quite large, with only the laparoscopic instruments, and so my technical ability was clearly superior to anyone else's in town, I realized that I was in for a good deal of difficulty with our medical justice system. It took about 5 or 6 years for that case to wind its way through. It ultimately went to trial in another State, required a lot of hours on everyone's part, and as far as I could tell, the only ones who really made out in that process were the people who were charging by the hour. And of course, the insurance company, being able to delay the payment of that claim for 5 years at a time when interest rates were considerably higher and their money did better in the stock market than it did going into a plaintiff's pocket, I guess they benefited as well. So I am interested in some of the administrative changes that might be made in the system to further the savings that I believe are the money that is inappropriately taken out of the healthcare system and spent on the medical justice system. Obviously, we want to see patients compensated who are harmed. Most

patients, though, that are harmed don't win the case through a lawsuit. I can remember at least one time having made an error in judgment and no case was ever brought. And this, I think, was because of being open and honest with the family during the course of things, being open and honest about how difficult the particular case was and being available to answer questions for the family as we worked through the process. Unfortunately, it doesn't always work out, and sometimes we do end up having to go to the courthouse, and I don't want to keep anyone from that ability, but at the same time, I also recognize that in order to keep our healthcare system solvent, there are going to have to be some limits placed on compensation.

Thank you, Mr. Chairman. You have been indulgent. I will yield back.

MR. DEAL. Ms. Capps is recognized for an opening statement.

MS. CAPPS. Thank you, Mr. Chairman.

Yes, indeed, we find ourselves once again discussing medical liability reform. Yet it is clear that differences do remain in our approaches, and that is no reason why we shouldn't begin to work towards a path of compromising. We absolutely should be looking at ways to remove medical liability as a barrier to accessing healthcare. And as we examine alternative ways of settling malpractice cases, we must be careful to protect patients' rights. We should ensure that settlements are conducted voluntarily from both ends, that the option to have one's case heard before a jury of one's peers always exists.

With the many innovative alternative dispute resolutions being discussed today, we cannot ignore the rising cost of malpractice insurance premiums. I constantly hear from physicians who are forced to retire early or leave their private practices for other jobs because they cannot keep up with the rising costs of malpractice insurance premiums. But time and time again, our leadership refuses to address the burdens posed on our healthcare system by insurance providers. While doctors are being forced to close up shop, these companies are raking in record profits. With all due respect, I would like to ask the Chairman if we could, in addition to the panel before us today, discuss that aspect of malpractice, the insurance companies and the accountability that I believe is lacking. Where is the justice here? If we are really going to work toward viable solutions and better healthcare delivery, we need to ensure that physicians can maintain their practices so that patients can have better access to quality care. If errors do occur on the part of doctors, patients must be assured that they are guaranteed proper recourse. We can not throw all of our weight into systems that remove objectivity, deny both plaintiffs and defendants the chance to present evidence to support their cases.

So as we discuss innovative solutions to medical liability, we must be sure to address both alternative methods of dispute and a commitment to lowering the cost of medical malpractice insurance premiums.

And I just want to mention on the side that another topic, which we have addressed that should be seen as a parallel situation, is the situation of medical errors and the morbidity and mortality that result from other aspects of delivery of the healthcare system. We seem to focus on going after the people in the courts. We could go such a long way to improving both the streamlining of administrative costs and the technology that would entail making this more open and transparent but also what is the healthcare delivery like in today's world with the shortages of professionals to provide the care and giving the patients the confidence in the system that we want them once again to have.

Mr. Chairman, I yield back.

MR. DEAL. I thank the gentlelady.

Dr. Norwood is recognized.

MR. NORWOOD. Thank you very much, Mr. Chairman, and a great thanks for having this, what I consider a very important hearing.

It is time we cut through all of the sound bites and get to addressing this problem. The premiums that providers pay today for their insurance is just continuing to skyrocket, and that actually is affecting access to care.

Having tried and failed, I believe we may have an opportunity to get it, if we can just think outside of the box. The same old way we have been doing this for the last 10 years clearly is not working, and I think this committee is smart enough to figure out a way to solve the problem, a different approach to it. It is not right when a physician, after so many years of education and training, has to actually stop providing care because Congress fails to address our medical liability crisis in a rational way. And that is, in fact, what is happening.

I am a dentist, and I know that doctors all over the Nation know that there are folks out there trying to make a quick buck abusing malpractice compensation laws. That's just plain wrong. I also know that doctors are being forced to retire early because of the insurance premiums that they pay. Simply put, our legal system is stacked against those who give up in their 20s, all of them generally, to learn to help others, who work very long hours and deal with, I think, in many cases, immense stress. Don't believe me? Well, according to a report by the Alliance of Specialty Medicine, 75 percent of neurosurgeons in 2004 were no longer operating on children. To the patient whose child's life is on the line, this is a problem. They are not understanding of that.

The situation in my home State is better, thanks to State reforms. However, in Augusta, Georgia, my home town, and city of around

200,000 people, Mr. Chairman, according to data collected by the alliance there, there was only one healthcare facility left with a practicing pathologist. In Statesboro, Georgia, south of us, women have to wait 6 to 9 months to have routine mammograms read. As this committee has already heard, the Athens Women's Clinic stopped delivering babies after 35 years. One lawsuit put the clinic out of the baby delivery business, period. Many doctors are practicing defensive medicine. I would say most doctors are practicing defensive medicine and avoiding innovative treatment options driving up medical costs and reducing, I think, quality of care. And they think so, too. They are really trying to practice law rather than medicine to defend their families, and that is wrong that they have to do that. Residents for high-risk fields are not being filled up. There are various surveys that have shown the number of physicians moving into rural areas continues to decrease and now it is up toward about 50 percent. I think folks, and I think most people in this room, find all of that unacceptable. I have said it before, and I am going to say it again, after economic damages, reasonable people should be able to agree, to an acceptable limit, non-economic damages. But it is time we start looking at the trial attorneys and the insurance companies, too, I agree with that, for their way in driving up the costs. If we don't do something, and it is our job, we will further jeopardize patients' health, because they cannot get access to a doctor. It drives me absolutely crazy, Mr. Chairman, that some of these physicians who have been out there practicing 30 years and have that amount of skill and wisdom over the years deciding they would rather go fishing than taking care of their patients because it is just too cumbersome anymore to stay in practice at that age. And we are losing some of the serious brainpower in medicine in this country by allowing this to happen.

I appreciate very much you having this hearing, and I look forward to our witnesses' testimony.

MR. DEAL. I thank the gentleman.

I recognize Mr. Gordon for an opening statement.

MR. GORDON. Mr. Chairman, I would like to yield some time to my friend from California who has to go to another meeting.

MS. ESHOO. I thank the gentleman.

I have an Intelligence Committee meeting that I need to get up to, Mr. Chairman.

Thank you.

MR. DEAL. We will just substitute the order, and we will come back to you, Mr. Gordon.

MS. ESHOO. Thank you, Mr. Chairman. And I thank my colleague from Tennessee.

I have a statement that I would like to have entered into the record, and I thank you for having this hearing.

Just a couple of comments.

Congress is really in, I think, a desperate need of some good ideas to help us get over the ditch that we are in. If, in fact, we remain where we are, and that some casting aspersion on lawyers, others somehow casting aspersions on doctors, we are not going to get anywhere. We do have a problem. I think that it is solvable, and I trust that that is what this hearing is about.

Now at the end of the day, I think all of us, if in fact we need them, want the best attorney on one side and the best doctor on the other. So I am not interested in casting blame on either profession. Both professions contribute a great deal to our society. I think that this issue is larger than patient and doctor and one attorney. We have very broad and large health systems in the country, and there are glitches and failures within these systems that helped produce some of the problems that we are trying to get our arms around.

So I thank everyone for being here. I began to read some of the testimony that has been placed in front of us. I am interested in this health court that is being proposed, and I am impressed with the bipartisanship of the organization with former Senators Howard Baker and Bill Bradley, members of the advisory board as well as Senator George McGovern and former Speaker Newt Gingrich. So I think we come together as an advisory board. Maybe we should be paying attention to what they are thinking and working on.

So I thank my colleague from Tennessee for allowing me to speak out of order, and Mr. Chairman, thank you for having the hearing and also to the text that comes out of it.

[The prepared statement of Hon. Anna G. Eshoo follows:]

PREPARED STATEMENT OF THE HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Thank you, Mr. Chairman.

The purpose of this hearing is to explore new ideas to make the American medical malpractice litigation system work better for patients and physicians.

In order to reduce the number of medical liability claims filed against healthcare providers, we must reduce the number of patients injured by negligence.

Today, we will hear that medical liability cases are clogging the courts, liability premiums are "skyrocketing," and that juries are awarding inconsistent and large awards to plaintiffs.

Some witnesses will call for tort reform, and limiting damages awarded in malpractice suits. We'll be discussing the creation of "health courts" to remove "frivolous lawsuits" from the traditional court system.

There are some cases without merit brought against doctors and hospitals, and something should be done about medical liability, but we need to place an emphasis on reducing the prevalence of medical errors when we consider any comprehensive solution.

One key way we can help reduce medical errors is to establish a national and interoperable electronic health record system (HIT).

Electronic health records are updated instantaneously and are portable, making legible, accurate and up-to-date information readily available to any doctor treating any patient in any setting.

Doctors will know exactly which medications a patient is taking, what chronic conditions a patient may have, and the types of procedures or treatments a patient may have undergone in the past.

This comprehensive profile of a patient's health history provides physicians a clearer picture of the patient they're treating, and helps reduce the risk of medical errors.

The promise of HIT is immense, but without appropriate safeguards and standards in place, these systems will not work. Unfortunately, the HIT bill passed by this Committee is inadequate. It does not address privacy protections in any meaningful way, nor does it create standards for interoperability across the system.

Finally, as we discuss the issue of medical liability, we need to remember that 90,000 Americans die each year due to medical errors. Most of these deaths could be prevented.

Every injured patient should be fairly compensated for any wrongs that are visited upon them because every person's life and health has worth, regardless of whether they have an income.

I look forward to hearing from the witnesses, and working to address this important issue.

MR. DEAL. I thank the gentlelady.

Mr. Shadegg is recognized for an opening.

MR. SHADEGG. Thank you, Mr. Chairman.

And I have a prepared opening statement, but I just want to insert it in the record and make some remarks.

Let me begin by saying I want to thank you, Mr. Chairman, for holding this hearing. I believe you and I have talked privately about how I feel it is vitally important that we bring some creativity to this topic. For too long, the Congress has looked at one solution and one solution only, and that solution is caps on damages. There are advocates of caps on damages, and there is evidence that in some instances they have worked. For philosophical reasons, I have problems with them. I am not convinced that the Government can decide in advance the value of any given economic loss or non-economic loss, and I am troubled by that as the only possible solution. And I believe we should be far more creative in looking at solutions. It seems to me that there are clearly proposals which would help in this area and perhaps special health courts, though I am concerned about federalizing this issue. This is an issue where current litigation occurs at the State level, and I am concerned that if we impose specialized health courts, we are imposing a Federal solution for what is a State issue.

But we owe it to the American people to address this problem. It is a very severe problem. In my State of Arizona, medical malpractice premiums are a crisis. They are driving doctors out of the practice. My own wife's physician, her OB/GYN who delivered both of our children, was ultimately forced to quit the practice because of the high cost of malpractice premiums.

But I would share in the views already expressed in opening statements here that this isn't just one issue. It isn't just trial lawyers. It is a combination solution. I have had very successful lawyers in Arizona who practice in the tort field come to me and acknowledge that the current system is broken. In part, there are lawyers with whom I have practiced, because I practiced in a firm that was made up of a number of tort lawyers before I came to Congress. These lawyers would come to me and say clearly the current system is broken and needs to be fixed. They are willing to discuss one of the options, which I think we should be exploring, which is the notion of loser pay, but modified by the notion that losing lawyer pays. I think it is important that in the American justice system we do not discourage people without resources from utilizing the court system. And to some token, there is no doubt that many lawsuits are abusive. Many lawsuits are brought without any factual basis. If you look at the statistics on medical malpractice suits, the vast majority are dismissed with no recovery whatsoever. I think creating disincentives for people that bring frivolous lawsuits or incentives for them to settle at an earlier point in time is something that we should be working on.

I can't speak on this topic without addressing one other issue, Mr. Chairman, and that is the issue of ERISA. Far too few Americans realize that the law this Congress enacted called the Employee Retirement Income Security Act, as interpreted by the United States Supreme Court, grants absolute immunity to an insurance company whose negligent decision kills someone. That simply is wrong. Pilot Life is the name of the case. It was written by Justice Sandra Day O'Connor. I am told that she later acknowledged that she felt it was a bad decision and that this Congress would correct it very quickly. But it seems to me anomalous that physicians in America are being sued so many times, so frequently, and so aggressively that they are being driven out of the practice at the same time that a law we passed grants absolute immunity to insurance companies whose negligence kills someone. Everyone makes mistakes. I make mistakes. Doctors make mistakes. Insurance companies make mistakes. When someone makes a mistake that hurts or kills someone, indeed, there should be a system by which there is compensation to the person killed or the family injured. And so absolute immunity is simply wrong. By the same token, a system that rewards people for bringing

lawsuits even without any merit is equally wrong. And I think it is far past time that we look at innovative solutions to this issue.

I hope you will also look at repealing the absolute immunity granted to insurance companies for their negligence, because no one should get a pass when they make a mistake that kills someone.

With that, I yield back my time.

MR. DEAL. I thank the gentleman.

I now recognize the gentleman from Tennessee, Mr. Gordon.

MR. GORDON. Thank you, Mr. Chairman.

A little over 25 years ago, I was sort of a do-whatever-you-want-or-whatever-you-need, small-town lawyer in Murfreesboro, Tennessee, and I took a criminal case pro bono. It was a burglary assault case, second offense. The defendant got a reduced sentence. He went to jail, but I think I did a pretty good job for a young lawyer, or any lawyer, for that matter. He didn't have anything to do while he was sitting there in jail, and so he filed a number of malpractice suits against me. They weren't successful, but I was a sole practitioner. That was all of the time that I had. That is how I made my living, and so it took my time. And so for any time I had defense cases after that, I filed defensive motions, brought witnesses before us that I didn't really need to, but I was trying to protect myself, because I didn't want to go through that again.

I think we are seeing the same thing in the medical profession. There is defensive medicine that is taking a large amount of money out of the limited amount of healthcare dollars that we have. And so I think we need to deal with this issue.

Listening to everybody's opening statements so far, it looks like if you locked us in a room, we might get that done, and I hope we could do that, because up until now, what has happened, and I will speak frankly and everybody can put their own opinion, but I think that the front office leadership here in the House has forced H.R. 5 as a my-way-or-the-highway. I voted for it, but it is a failure. And I think it is partly because they want to keep the issue alive to raise money.

Now on the other side, in my party, some of the folks that would be the first to condemn the NRA for their no-camel's-nose-under-the-tent, won't make any kind of concessions either. And so again, I hope that Chairman Deal will find the key, lock us in here, and try to work this out. This is important, and I think looking for alternatives is a good way to approach it.

And I will just mention one alternative. Between 1993 and 2003, the number of visits to emergency rooms increased by 26 percent, yet the number of emergency rooms decreased by 14 percent. Every minute an ambulance is diverted somewhere in America from an emergency room because it is filled. Three-fourths of emergency room directors in this

country say that they can't get specialists because the specialists don't want to deal with the malpractice and other problems there.

And so I have introduced a bill, H.R. 3875, that deals with this situation. You see right now, if you are a public health doctor, then you don't have to worry about malpractice, because there is a Federal fund that takes care of compensating those people that have had those problems. It would seem that if an ER doctor is going to treat and indigent without any kind of compensation that they also ought to be able to plug into this same fund. But that is a small group, but I think that it is one way to look at a comprehensive approach. And I know many of you have other things. Hopefully we can plug these in together and really make a sincere effort, because healthcare costs are simply killing us in this country. Whether you are the CEO or someone who works down the line, you know that healthcare costs are affecting us all. There are a limited number of healthcare dollars. This isn't a cure-all, but this is one way to better use those.

And so again, Mr. Chairman, let us get out the key and work this out.

Thank you.

MR. DEAL. I thank the gentleman.

I now recognize the Chairman of the full committee, Mr. Barton from Texas.

CHAIRMAN BARTON. Thank you, Mr. Chairman.

I have a very excellent, but long opening statement. It is about eight pages, so I am going to submit it for the record.

Thank you for holding the hearing. Thank our witnesses for being here.

I will point out that in Texas we reformed our medical liability system. In the last 2 years, we have had 4,000 new doctors apply to practice and we think this year we are going to get another 4,000. So it does work, and I hope that this hearing leads to legislation that might help nationally what we have done in the last several years in Texas.

Thank you.

[The prepared statement of Hon. Joe Barton follows:]

PREPARED STATEMENT OF THE HON. JOE BARTON, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Thank you, Chairman Deal, for holding this hearing on the important topic of medical liability reform.

As we all know, medical liability reform has been a topic of intense debate. From courtrooms to examining rooms and from state houses to Congress, the search for ways to fix our broken medical liability system is continuing. Passions run high, but the stakes are high, too. We are talking about nothing less than ensuring continued access to quality medical care for the American people. We are also talking about reforming the medical liability system to make it fairer and more efficient for all participants, but especially for patients.

I continue to be encouraged by the successful medical liability reforms being enacted in the states. In my home state of Texas, for instance, where we enacted common-sense reforms and even went as far as to amend our state constitution to make them stick, the good news continues to pour in. From Texas the message is clear: effective reforms increase access to quality medical care for patients.

In just three years, Texans have seen medical liability insurance premiums fall and thousands of new doctors coming into the state. More than 4,000 new physicians applied to practice in Texas during the last three years, and the Texas Medical Board anticipates that we will add another 4,000 new doctors this year alone. The benefits are being felt right now by patients all over Texas, but they are especially great in rural areas where access to medical care is more difficult. In rural areas, every additional doctor's office, clinic, or ER specialist on call can mean the difference between life and death.

While access to care is a crucial concern part of any medical liability reform, of equal importance is protecting those patients who have a legitimate claim of medical malpractice. On this point, the status quo fails to deliver. Patients must often endure years of long, drawn-out litigation before receiving compensation for their injuries. When compensation finally arrives, lawyers' fees and expert witness fees often take the lion's share of the award.

Additionally, in the current climate, doctors are frustrated by a Byzantine legal system that takes them away from their patients and threatens to ruin them financially and professionally, regardless of whether the claims have any merit. The cost of defending yourself is just as high for frivolous lawsuits as it are for honest ones, and they often run into the tens of thousands of dollars. The result of all of this is a culture of silence, in which health care providers are afraid to admit to their mistakes and so opportunities to prevent mistakes from happening again are lost.

Finally, we know that the current medical liability system is missing the point. Study after study has told us that the real problem is errors in the web of people, computers, devices, and medicines that make up our modern health care system. According to the experts, systemic errors, not individuals, cause the vast majority of medical injuries. Yet the current liability system is obsessed with finding somebody to blame. The one holding the scalpel or the last one to touch the patient when things went wrong is the automatic target. It seems to me that we are missing the real problem and that we are not any safer for it.

The status quo is no longer acceptable. I'm excited to hear testimony from our distinguished panel of expert witnesses on innovative proposals that can alleviate our nation's medical liability crisis, and I look forward to examining each of these proposals in greater detail as we continue to go forward.

Thank you again Chairman Deal for holding today's hearing and welcome to our witnesses.

MR. DEAL. I thank the gentleman.

Mr. Pitts. Mr. Ferguson.

MR. FERGUSON. Thank you, Mr. Chairman.

I am really pleased that we are having this hearing and appreciate your leadership on this issue, because there are some very serious problems with our healthcare and medical liability system. It fails our patients. It fails our physicians. It is failing our country. The process is failing physicians by encouraging predatory and frivolous lawsuits that bring skyrocketing malpractice insurance premiums and, frankly, the practice of defensive medicine. Studies have found that in high-risk

specialties, practically speaking, all of the physicians surveyed had practiced some form of defensive medicine. And while a dollar amount is hard to peg for how much this is costing the system, some estimates say that it costs the healthcare system roughly $70 billion a year.

The process is also failing the rest of us, the patients, the consumers of healthcare in our country. Recently, a study published in the New England Journal of Medicine found that for every dollar paid to compensate victims of medical malpractice, 54 cents, more than half, of that dollar goes to administrative expenses, including lawyers' fees and experts' fees and court costs. The same study found that these plaintiffs had to wait over 5 years to receive compensation that is less than half of the total amount.

We are commissioning lawyers, we are stifling doctors, and most importantly, we are cheating patients by limiting access, by increasing costs, and compromising the quality of care. I voted a number of times for the House bill that we have passed to reform the medical liability system. Clearly, that has not become law, and we need to be thinking of some alternative solutions to try and address this problem, and I welcome the insights that our panelists will lend and their expertise in how we can save our Nation's healthcare system from this growing problem, particularly in my home State of New Jersey where we have an acute crisis. Three years ago, we had a baby born during the physician job action in New Jersey. A physician walked off the job for a week to raise profile of this crisis that they are facing in our State. We happened to have a baby that week. Now our physician was there to deliver our child, obviously, because they were providing emergency and unscheduled care to their patients, but it really was a wake-up call for me in how serious this problem is. And our physician who delivered our child, her partner and her practice has left the State of New Jersey, and our physician is bright, a woman who has spent years and years studying and investing time and energy and resources because she wants to deliver babies. She is considering giving up the practice of obstetrics altogether. That is a serious crisis, and if it is that bad in New Jersey, it is clearly that bad in other places around the country where there is even less access to good quality healthcare and good physicians.

So I am delighted of the hearing. I appreciate your leadership, Mr. Chairman.

And I look forward to hearing our witnesses.

MR. DEAL. I thank the gentleman.

I am going to introduce our distinguished panel at this time, but I would tell you before we proceed, these are probably the most encouraging opening statements I think that I have heard in a long time. I hope that that is an indication that what you are going to tell us is going

to be received by both sides of our subcommittee, and I think that is a healthy thing.

First of all, Ms. Michelle Mello, who is the Associate Professor of Health Policy and Law at the Department of Health Policy and Management at Harvard University; Mr. James M. Wootton, an attorney with a law firm here in Washington, D.C.; Mr. Paul Barringer, General Counsel of Common Good; Ms. Margaret VanAmringe, who is Vice President of Public Policy and Government Relations of the Joint Commission on Accreditation of Healthcare Organizations; Mr. Jeffrey O'Connell, who is a Professor of Law at the University of Virginia; Ms. Joanne Doroshow, who is the Executive Director of the Center for Justice & Democracy; and Ms. Cheryl Niro, who is a partner in a law firm in Chicago and is appearing on behalf of the American Bar Association.

Ladies and gentlemen, we are pleased to have you here. I will tell you in advance that your written testimony has been made a part of the record, and we would ask, if you would, in the 5 minutes allotted to you, please, to summarize your testimony, and we will follow that with questions from our subcommittee.

Dr. Mello, I would recognize you first.

STATEMENTS OF MICHELLE MELLO, J.D., PH.D., ASSOCIATE PROFESSOR OF HEALTH POLICY AND LAW, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HARVARD UNIVERSITY; JAMES M. WOOTTON, PARTNER, MAYER, BROWN, ROWE & MAW, LLP; PAUL BARRINGER, GENERAL COUNSEL, COMMON GOOD; MARGARET VANAMRINGE, VICE PRESIDENT, PUBLIC POLICY AND GOVERNMENT RELATIONS, JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS; JEFFREY O'CONNELL, J.D., SAMUEL H. MCCOY II PROFESSOR OF LAW, UNIVERSITY OF VIRGINIA; JOANNE DOROSHOW, EXECUTIVE DIRECTOR, CENTER FOR JUSTICE & DEMOCRACY; AND CHERYL NIRO, PARTNER, QUINLAN AND CARROLL, LTD., ON BEHALF OF AMERICAN BAR ASSOCIATION

DR. MELLO. Mr. Chairman, members of the subcommittee, thank you for the opportunity to speak with you today about some of the things I have learned in the course of my research at Harvard on the medical liability system.

I am a lawyer and a health services researcher by training, and my work focuses on using empirical analysis of data to try to understand how well the system does the things it is supposed to be doing and also how it affects healthcare and quality and safety of health services.

The medical malpractice system is the best study aspect of our entire tort liability system. We have over 30 years of research on practice claims data, insurance data, and medical records with which to draw some inferences about how the system works. The conclusions that I draw, based on the study of this work, are fairly pessimist, but I am optimistic about the process for reform.

I would just emphasize three points from my written testimony about the performance of the medical liability system.

First, the system helps very few of the patients that it is intended to help. Secondly, the system hemorrhages money in the process of doing this. Third, the system has some very painful side effects on medicine.

The first part is that the system does a very poor job of getting compensation to the people who are entitled to it under the rules that we have set up. We know, from research studies at Harvard, that only between 3 and 5 percent of patients who are seriously injured by medical negligence file a malpractice claim. Only about a quarter of those claimants, and less than half of all malpractice claimants, recover money in our system. Contrary to popular wisdom, malpractice plaintiffs are especially unlikely to receive compensation if their claims are decided by a jury, they lose four out of five malpractice trials. So although the juries have a lot of resonance to us and to me personally as a lawyer, the data doesn't speak to the notion that juries serve patients' interests.

The second point is that we spend an absolute fortune getting money from A to B in this system. As one of the distinguished committee members mentioned, all research at Harvard shows that for every dollar we pay in malpractice compensation costs, 54 cents are spent on lawyers, court costs, insurers, and other administrative expenses. There are much more efficient ways to get money to injured people. Even workers' compensation programs, which are not exactly known for being low-bureaucracy organizations, do it at overhead rates of between 20 and 30 percent rather than 54 percent. Many administrative compensation systems get that number down as low as 10 percent. The degree of inefficiency that we have been tolerating in our malpractice system is absolutely staggering.

The third point is that the court litigation process has some painful side effects on American medicine. Although the problem is that cost of defensive medicine behaviors aren't known with precision, we do know that they exist, they occur often, and they implicate very expensive services. Another important effect of a liability system that revolves

around the concept of negligence is a creation of fear and stigma among medical professionals. Even if we don't care particularly about doctors, this should be a concern for us, because it makes it harder for patient safety efforts to cultivate what they call "a culture of safety" in medicine. A legal process, which is punitive and stigmatizing, because it focuses on the concept of fault or negligence, instead promotes a culture of silence around medical errors. It is hard to move the dialogue about errors to notions of preventability and fail-safe fixes when our legal system is so fixated on the concept of negligence and individual failures. Now our medical liability system costs us dearly in monetary terms, in lost opportunities to compensate injured patients who have preventable injuries, and in lost chances to improve patient safety.

These are fundamental problems and they can't be addressed with incremental reforms such as damages caps. Innovative reforms are needed that can make compensation more accessible to patients who were preventably injured and that boost the efficiency and reliability of the compensation process. Several interesting ideas have been percolating over the last two malpractice crises. The most promising reform approaches are those that create alternative processes for a dispute resolution. The approach I favor is the health courts model, which proposes to experiment with moving medical injury claims to an alternative administrative compensation process that relies on mutual experts, decision guidelines, and a standard for eligibility that encompasses a broader group of patients than those who are injured by negligence. Early offer programs and other alternative dispute resolution processes are also very worthy of consideration.

In summary, the problems with the liability system challenge us to rethink our attachment to the current system, especially our attachment to juries. There are great ideas waiting to be tested. Small-scale demonstration projects at the State or even sub-State level are a good way to do this at low cost and at low risk.

I am happy to discuss these ideas further in the question-and-answer period or at any time convenient to you, and I thank you again for hearing me today.

[The prepared statement of Michelle Mello, J.D., Ph.D., follows:]

PREPARED STATEMENT OF MICHELLE MELLO, J.D., PH.D., ASSOCIATE PROFESSOR OF HEALTH POLICY AND LAW, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HARVARD UNIVERSITY

Summary of Testimony

The American medical liability system performs its core functions poorly, at tremendous cost and with unfortunate effects on health care delivery.

1. *Compensation of injured patients*: Less than 5% of patients who are seriously injured by medical negligence file malpractice claims, and less than half those who claim receive compensation. Patients are especially unlikely to receive compensation if their claims are decided by a jury.
2. *Deterrence of medical error*: There is very little evidence to suggest that the threat or experience of being sued leads doctors and hospitals to make systematic improvements in the safety of the care they deliver.
3. *"Corrective justice"*: Although the system gives claimants their "day in court" and an opportunity to hold health care providers accountable for their negligence, it does not secure other important aspects of "making whole" patients who are injured, such as hearing an apology or public admission of responsibility. The system provides no corrective justice to the 95-97% of seriously injured patients who don't file a claim.
4. *Efficiency*: Exorbitant amounts of money are spent to get compensation to the few patients who receive it. On average, about 55 cents on the dollar in malpractice system costs are spent on administrative expenses.
5. *Side effects on health care delivery*: Among the unintended effects of the malpractice system on health care are "defensive medicine" behaviors, which increase the costs of care, and creation of a culture that discourages openness and information-sharing about medical adverse events.

These are fundamental problems that cannot be addressed by incremental reforms, such as damages caps. Innovative reforms are needed that can

- make compensation more accessible to patients who sustain preventable injuries;
- make the process of determining eligibility for compensation cheaper and faster;
- make compensation decisions more accurate and reliable (ideally through incorporation of the best available clinical evidence into decision making);
- make assessments of damages more consistent across similar cases; and
- make the system less threatening to doctors and encourage transparency about errors

The most promising reform approaches are those that create alternative processes for dispute resolution. Among these are the "health courts" model—moving medical injury claims to an administrative system that relies on neutral experts and has a broader eligibility standard than the tort system—and "Early Offer" programs.

I am grateful for the opportunity to speak with you today about America's medical liability system and the need for innovative solutions to improve it.

I am an Associate Professor Health Policy and Law at the Harvard School of Public Health. I am trained as a lawyer and health services researcher, and my work focuses on the empirical analysis of medical liability. I examine data on malpractice claims, insurance costs, and the organization and delivery of health services to try to understand how well the liability system is performing on its main functions and what effects it has on the quality and availability of health care.

My work has led me to conclude that our medical liability system is in need of significant reform, and that the conventional array of tort reform options will not get us where we need to be. Farther-reaching changes are required. In my testimony today, I will describe what is known about the performance of the medical liability system on several key measures, and comment briefly on reforms that would boost its performance.

Measuring the Performance of the Medical Liability System

Legal scholars think about the tort liability system as having three core functions: injury *compensation*, injury prevention (sometimes called "*deterrence*"), and *corrective justice*. Two other key criteria for thinking about how well our medical liability system performs are how *efficiently* it performs its core functions, and whether it has unwelcome *side effects* on health care delivery. I will review the evidence on each of these performance measures in turn.

1. Compensation

The most basic function of a medical liability system is to get compensation to people who are injured by medical care that falls below a particular standard of care. In our system, that standard of care is negligence. A well-functioning liability system should get fair compensation to all or most of those patients who are injured by negligence (and who desire compensation), and should give money to few or none of those patients whose injuries are not due to negligence.

This is not the way our system works. Three large-scale studies conducted by Harvard researchers over the last 15 years, involving reviews of thousands of hospital medical records and malpractice claims files from liability insurers, produced the following findings:

- Between 95% and 97% of patients who sustain serious injuries due to negligence in the hospital never file malpractice claims.[1, 2]
- Of those patients who do file claims, the majority (46%) receive no compensation.[3] Thus, overall, 1 to 2 percent of patients injured by negligence are compensated by the system.
- Patients whose claims are decided by a jury are especially unlikely to receive compensation (21% versus 61% for claims resolved out of court).[3]
- The system attracts both meritorious and non-meritorious claims.[1-3] In about a third of cases, the injury does not appear to be due to errors in care (in the judgment of an expert reviewing the medical and litigation record).[3]
- Juries are tough even on patients with meritorious cases. The odds that a claim involving a medical error is denied compensation are about 4 times higher if a jury decides the case than if the case is resolved out of court, even after controlling for injury severity and other characteristics that may differ across the two groups of claims.[3]
- The system pays both meritorious and non-meritorious claims,[4] although it is more likely to award money in meritorious cases. The system "gets it right" about three quarters of the time: 3 out of 4 non-meritorious claims are denied payment and 3 out of 4 meritorious claims receive payment.[3]
- Jury verdicts tend to produce large variation in damages awards for injuries of similar severity.[5]

Thus, the malpractice system appears to be doing a reasonable job in two specific aspects of its compensation function: (1) it is not predominantly attracting claims that are frivolous; and (2) it is usually directing compensation to meritorious claims rather than non-meritorious ones. Portraits of a system inundated with costly frivolous lawsuits are overblown. So are portraits of the system as a "lawsuit lottery," where awards are unconnected to the merits of the claim.

But to interpret this pair of findings as indicating that the medical liability system is performing its compensation function well would be misguided. There are three other factors to consider. First, a system that only helps about 1 in 50 of the patients who are eligible for compensation under the rules we have set up is not doing a good job of providing compensation.

Second, a system that awards very different amounts of money—even different amounts of "pain and suffering" damages, which should not vary according to plaintiff characteristics such as age and earning power—to plaintiffs with similar injuries raises questions about fairness in compensation.

Third, although non-meritorious claims do not predominate in the system, they do account for a third of the caseload. One likely explanation is that plaintiffs and their attorneys have some initial uncertainty about whether a case is likely to succeed. One reason for this is that it's often hard for a patient to find out what happened in an episode of medical care that had a bad outcome; filing a lawsuit may be the only way to get information. Another reason is that patients, lawyers, and even doctors may be unsure about what the legal standard of care (negligence) requires of them in particular circumstances. Even expert reviewers often disagree about what constitutes negligence. Thus, claims that ultimately prove non-meritorious may not appear so at the outset (and vice versa).

Overall, if I was to grade the malpractice system's performance on the compensation function, I'd give it a **D**.

2. Deterrence of Medical Error

The second core function of the tort liability system, and the basis on which it is most often defended, is to deter negligence and thereby prevent injuries. In theory, the system creates incentives for doctors and hospitals to take appropriate precautions to prevent injuries by imposing an economic penalty when they don't.

This theory rests on some assumptions about the organization of health care that aren't borne out in reality, and empirical evidence suggests that we don't get much deterrence out of the system. One important problem is uncertainty. Deterrence rests on the assumptions that health care providers understand what the law is asking them to do—that is, what the standard of care is—and what the penalty will be if they don't comply. But the negligence standard is ambiguous and doesn't always clearly signal what appropriate care constitutes. That's particularly true in a legal system that produces little or no written record that doctors could consult. Settlements and insurers' case files are confidential, and jury verdicts produce no written decisions. It's also hard to gauge what the penalty for negligence in a particular circumstance would be, because there is so much variation in litigation outcomes and awards.

Another key assumption is that physicians actually "feel" the economic consequences of their negligence. This tends not to be true in reality. Nearly all physicians have liability insurance. Although in theory, judgments can go beyond the limits of malpractice awards, this is extremely rare in practice. Moreover, liability insurance isn't individually experience rated, meaning that the premiums that a particular doctors pays don't change from year to year depending on whether she had a judgment against her. That makes it very different from car insurance: if we are at fault in a car accident, we pay for it the next year in higher premiums. That makes us try hard to avoid accidents. Malpractice insurance, in contrast, is generally priced only by specialty and geographic region.

Another reason doctors and hospitals don't tend to feel the consequences of negligence is that so few instances of negligent injury result in a malpractice claim. Most of the time, nothing happens.

All of these factors should make us skeptical of the deterrent value of the malpractice system. And indeed, there is very little empirical evidence that deterrence occurs in any systematic way. For example, in obstetric care, the best-studied field, research has failed to identify any differences in the quality of care rendered by obstetricians with varying histories of malpractice claims.[6] Other studies found no systematic improvement in any of several birth outcomes associated with a physician's prior claims experience.[7, 8]

Proponents of the tort system point to some isolated but impressive examples of safety improvement to rebut this argument. The leading example is the successful effort of anesthesiologists to reduce their malpractice claims by reducing the incidence of anesthesia injuries.[9]

Taking into account such anecdotes, overall, I would give the malpractice system an overall grade of **C** on its deterrence function.

3. Corrective Justice

The third major function of the tort liability system is to provide claimants with "corrective justice." The notion of corrective justice has two strands: a soft one that calls for financial restitution to make victims "whole" after they are injured by negligence, and a harder one that addresses a human impulse to express anger towards, condemn, and punish wrongdoers. Both strands point to having a public process to hold wrongdoers accountable for their actions.[10]

The tort liability system fits well with notions of corrective justice. Claimants gain access to a means of learning about what happened to them, showing health care providers how their actions have affected them, demanding that providers accept responsibility, receiving money, and (at least in theory) imposing a financial penalty on the provider, as well as the reputational and psychological burdens of being sued. Research indicates that malpractice plaintiffs are often motivated to sue by feelings of anger and frustration and a desire to get back at providers who have not communicated appropriately or dealt sensitively with them,[11-13] so these opportunities may be highly valued by claimants.

But other research suggests that injured patients' corrective-justice needs could be met through a less punitive process. What many malpractice claimants want is to hear the provider acknowledge that an error occurred that hurt the patient, apologize or otherwise take responsibility for what happened, and assure the patient that attempts will be made to fix the problem so that others will not be similarly hurt.[14] That does not require malpractice litigation and is not facilitated by the adversarial litigation process.

Thus, although the medical liability system serves some aspects of corrective justice fairly well, it ignores other aspects. Moreover, it's important to remember that only claimants get the benefit of corrective justice in the system, and less than 5% of patients with serious injuries due to negligence ever become claimants.

These considerations lead me to give the medical liability system an overall grade of **B** on its corrective justice function, and that is probably generous.

4. Efficiency

A well-performing medical liability system would perform its core functions efficiently, minimizing transaction costs and waste. Our system does not work this way. Research at Harvard shows that for every dollar paid in compensation to plaintiffs, 54 cents goes towards administrative costs—the costs of lawyers, experts, insurers, and so forth.[3] This is similar to previous estimates.[15] In part, these high costs reflect the length of litigation. On average, in our study, 3 years elapsed between the opening and closing of a claim.

Compared to other compensation systems, this is a tremendously high overhead rate. The equivalent figure for workers' compensation systems, for example, is generally in the 20-30% range.[16, 17] For many disability insurance schemes—public and private—it runs as low as 10-15%.

Another telling feature of these administrative costs is where they get spent. In our recent study of hospital malpractice claims, about 80% of the administrative costs were incurred resolving meritorious claims. This finding highlights that the process of proving negligence is lengthy and costly. It typically requires extensive legal discovery and testimony by multiple expert witnesses. The negligence standard itself is murky and

contested; even in the controlled and non-adversarial context of research studies, expert reviewers frequently disagree about the presence or absence of negligence in a particular case of medical injury.[18] The pressures and biases of the litigation process only compound this disagreement.

If a more efficient system existed for determining eligibility for compensation, the money currently absorbed by administrative costs could be redirected toward compensation. A worthy target for that money would be patients who experience medical injuries that are both severe and preventable but don't receive compensation because they never file a claim.

In terms of efficiency, I would give our medical liability system a grade of **F**.

5. Side Effects on Health Care Delivery

It is reasonable to judge the medical liability system on the basis of its unintended effects on health care providers and the quality of care, as well as its performance on its core functions. Unfortunately, the side effects of the system are predominantly negative.[10]

One important effect is *defensive medicine*. Defensive medicine refers to physicians changing the way care they deliver care—ordering unnecessary tests, for example, or ceasing to perform high-risk procedures—in order to try to minimize their exposure to malpractice litigation.

It is not known with any reasonable degree of certainty how prevalent defensive medicine is, what its health impact is, or how much it costs the health care system.[10, 19] But there is solid evidence that it exists, and its adverse impact may be very substantial.[20, 21] Recent research in Pennsylvania by my group at Harvard suggests that doctors in specialties like orthopedic surgery and obstetrics are especially prone to this behavior, and that it gets worse during so-called "malpractice crisis" periods.[21]

A second effect that the liability system has on health care is to create friction with efforts to improve *patient safety*.[22] Building a culture of safety in medicine requires that physicians be willing to share information about injuries with systems that can use it to learn about injury prevention. Emulating other industries involving complex services that are prone to error, such as aviation and nuclear energy, the patient safety movement has sought to create mechanisms for immediate reporting of poor outcomes and analysis of what may have gone wrong.

The threat of malpractice litigation in our present liability system undercuts these efforts to encourage openness.[23] Doctors are fearful that information they provide may be used against them in court, and aware of the stigmatizing effect of a finding of negligence, which doctors tend to equate with incompetence.[24, 25] Although there is little evidence with which to gauge the role that legal fears, as opposed to other factors, have played in discouraging doctors from disclosing and reporting medical injuries,[9] the notion that liability pressure is a major driver fits the conventional wisdom among physicians and has some empirical support.[26] Certainly, the tort system isn't making it any easier for the patient safety movement to accomplish its goals.

Overall, I would give the liability system a **D** grade for its effects on health care delivery.

Promising Options for Reforming the Medical Liability System

In summary, the medical liability system does not perform well on its major performance criteria. The most trenchant criticisms that can be made, based on the evidence gathered in research studies, are:

- Many patients with severe, preventable injuries miss out on compensation, sometimes because their legitimate claims are not paid but much more often because they never bring a claim.

- Juries do not decide the vast majority of claims, and when they do, plaintiffs usually lose.
- The process is slow and extremely costly.
- Malpractice litigation and the threat of it do not appear to result in systematic improvements in patient safety; rather, the liability system tends to thwart patient safety initiatives.

These are fundamental problems that cannot be addressed by incremental reforms, such as damages caps or pretrial screening panels. Creative thinking is needed to:

- Make compensation more accessible to patients who sustain preventable injuries;
- Make the process of determining eligibility for compensation cheaper and faster;
- Make compensation decisions more accurate and reliable (ideally through incorporation of the best available clinical evidence into decision making);
- Make assessments of damages more consistent across similar cases; and
- Make the system less threatening to doctors and encourage transparency about errors

I believe that experiments with alternatives to medical tort litigation are a good idea. How promising and successful these alternatives are will depend on their design features.

With support from the Robert Wood Johnson Foundation, my research group at the Harvard School of Public Health, in collaboration with Common Good, has been working on the design of such an experiment. Paul Barringer from Common Good will outline the major features of our approach, which we call "health courts," in his testimony today. In brief, the idea is to move medical injury claims into an administrative system that relies on neutral experts, and expand the pool of patients who are eligible for compensation.

There are a variety of other innovative alternative dispute resolution (ADR) approaches that also warrant serious consideration. Jeffrey O'Connell will discuss one of these, the "Early Offer" program, in his testimony today.

Much is unknown about how well alternatives to traditional malpractice litigation will work. Therefore, the appropriate next step is to launch demonstration programs accompanied by careful evaluation to assess how well the alternative models have performed relative to tort litigation.

Conclusion

One of the perplexing aspects of the tort reform debates of recent years is that they rarely engage the system's true failings. Instead, they tend to fixate on traditional reforms, despite evidence that those approaches are not very helpful.[19] There are good reasons to criticize the system's performance, but it is important to do so for the right reasons, because the diagnosis informs the treatment. To be effective in improving the performance of the medical liability system, reforms must tackle the core problems that I have outlined.

That may mean rethinking our historical attachment to juries as a means of resolving malpractice disputes, especially if we are committed to the goal of getting compensation to more injured patients. Contrary to the popular wisdom, juries tend to be tough on malpractice plaintiffs. Plaintiffs lose about four in five trials. Moreover, for plaintiffs who do win, trials are an expensive way to obtain compensation because the substantial costs incurred by the plaintiff's lawyer in getting to trial are paid by the successful plaintiff through contingent fees.

Finally, the vast majority of medical malpractice claims will not go before a jury. National statistics suggest that only about 5-10% of claims reach trial, and this statistic

has held fairly steady over time. In other words, approximately 55,000 of the 60,000 patients who seek compensation for medical injuries each year will resolve their claims out of court. It is imperative that the system work well for them. Therefore, in choosing among reform options, we should be careful not to hold the interests of the many hostage to the interests of the few, especially when serious questions surround how well the interests of the few are served by the current system.

Although I have painted a rather bleak picture of the medical liability system, I am optimistic about the prospects for improving it. There are good ideas waiting to be tested. I hope that you will give them serious consideration.

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MR. DEAL. Thank you.

Mr. Wootton.

MR. WOOTTON. Thank you, Mr. Chairman and members of the subcommittee for giving me this opportunity to share my perspective on the shape of the next generation of national medical liability reform and the direction it might take, and most importantly, its potential contribution to the goal of transforming our healthcare system to better serve the needs of patients.

I want to make clear that while I have discussed a lot of these ideas with many stakeholders, these views are my own and are based on my career in legal reform.

In my opinion, the current court-based medical liability system, even after the usual reforms are implemented, does not well serve the interest of patients or healthcare professionals, nor will it facilitate desirable healthcare transformation. There are, in fact, better alternatives.

At a time when the viability of the current reform approach is embodied in H.R. 5 is being questioned, versions of which have passed the House a number of times but have never passed the Senate, proponents of reform have the opportunity to reclaim the debate.

Advocates of medical liability reform, in my opinion, should now put more emphasis on patient safety and put liability reform in the context of a broader healthcare transformation agenda. The healthcare industry and policymakers can now go on record offering a new contract with the public, which is that we will do all we can to reduce the avoidable risk of medical treatment but also provide fair, fast, and accessible access to healthcare and medical liability compensation. Patients are concerned about access to healthcare. I think the Chairman is absolutely right. But they are also concerned about the system to which they have access. They care about patient safety. They care about finding new cures for diseases. They care about expedited drug approval. They care about improving the doctor-patient relationship, and they care about improving the patient literacy. All of these goals are related in some way to the medical liability system.

Today, the tort system is seen as an impediment of the free exchange of information related to medical errors and adverse events. The Institute of Medicine has repeatedly declared that patients' safety is hindered by our current system of legal liability which discourages the disclosure of very vital information that could reduce avoidable medical errors.

It is system errors, not individual errors by doctors that are most prominent in the Institute of Medicine's concern. Therefore, I am suggesting the creation, at the national level, of the National Center for Medical Data, and at the State level, a patient safety and compensation system that works in a coordinated fashion. This is based on the notion that the experience rate of compensation systems with a very low cost of claiming would drive up the standard of care more effectively than the random imposition and punitive or extreme damages in the tort system today. There is a recent CRS study that provides a lot of data that supports this kind of approach.

If we take this holistic approach, then we can focus on prevention. With or without legislation, there should be a lot more emphasis on preventing disease. A lot of people look at the cost equation and look at the incidents of disease and the cost of treatment. We never look at lowering the incidents of disease. We always look at lowering the cost of treatment. I think we ought to spend more time focused on lowering the incidents of disease, with or without legislation.

But if there is legislation, and I think, really, we are discussing today a framework, not a detail, it should include a National Medical Data Center. It should go along the work that was done by Congress to provide information to patient safety organizations. There should be an electronic healthcare imitative that provides leadership and incentives at the State level to break through the inertia that is preventing the adoption of electronic medical records and patient safety programs.

I do think there is a case to be made for uniform national standards. We are in a different world today. I was in the Reagan Administration. We struggled over the Federalism Executive Order. We did it in an era that was very different from today. Now healthcare has become such a large cost of business, it effects the competitive position among manufacturers. Healthcare, itself, is a national industry.

I think that we should look very strongly at creating alternatives at the State level or encouraging alternatives at the State level that take into account the fact that it is with an experienced rate of compensation system and trusted regulators where we overcome the distrust of the very bodies that are charged with protecting the public in giving them tools they need so that we can get a bipartisan consensus on what we need to do to go forward.

I have some slides, which are available during the question-and-answer period, if they are of interest, and I look forward to the committee's questions.

Thank you, sir.

[The prepared statement of James M. Wootton follows:]

PREPARED STATEMENT OF JAMES M. WOOTTON, PARTNER, MAYER, BROWN, ROWE & MAW LLP

Summary

The current tort-based medical liability system – even after the usual reforms – does not well serve the interests of patients or healthcare professionals nor will it facilitate desirable healthcare transformation. There are better alternatives.

Advocates of medical liability reform should put more emphasis on patient safety and put liability reform in the context of a broader healthcare transformation agenda. The healthcare industry and policymakers could offer a new contract with the public — "We will do all we can to reduce the avoidable risks of medical treatment but also will provide a fair, fast and accessible system to compensate patients when avoidable injuries do occur." Patients are concerned about access to healthcare, but they also want to improve patient safety, find new cures for diseases, expedite drug approval, improve doctor-patient relationships and increase patient literacy.

Today, the tort system is seen as an impediment to the free exchange of information related to medical errors and adverse events. The Institute of Medicine (IOM) has repeatedly declared that patient safety is hindered by our current system of legal liability which discourages the disclosure of the very information that could reduce avoidable medical errors. As the IOM found, it is not mistakes by doctors that cause most medical injuries – it is system errors or an absence of a system. Therefore, I am suggesting the creation of a National Medical Data Center at the federal level and Patient Safety and Compensation Systems at the state level where the medical liability system is seen as a component of a much larger patient safety system. These new systems would facilitate – not inhibit – positive healthcare transformation and serve the interest of all the stakeholders in our healthcare system.

The country is at a crossroads in dealing with healthcare – either moving toward more government involvement and control or focusing on better defining and executing the government's necessary role in a market-based healthcare system that maximizes individual freedom and provides the necessary incentives for hard work and innovation.

The goal of this legislation would be to provide the leadership and expertise needed to overcome inertia and move the country toward a shared vision of a transformed healthcare system. It also recognizes that legal reform is a critical step on that path. To pass this legislation and, indeed, to achieve the broader goals of healthcare transformation will require bipartisan cooperation and a coordinated effort by employers, health insurers, medical professionals and medical manufacturers with patient and consumer groups.

It is reasonable to conclude that widespread adoption of some version of this systematic approach to medical liability and the electronic medical systems that promote patient safety could save the country as much as $114 billion out of the $1.6 trillion currently spent on healthcare annually and, more importantly, thousands of lives.

* * * *

James M. Wootton is a partner in Mayer, Brown, Rowe & Maw LLP and former president of the U.S. Chamber Institute for Legal Reform. Wootton was the founder and president of the Safe Streets Coalition and helped create the National Center for Missing and Exploited Children and other national programs while an official of the Reagan Justice Department.

Thank you, Mr. Chairman, for the opportunity to share my perspective on the shape the next generation of national medical liability reform might take and its potential contribution to the goal of transforming our healthcare system to better serve the needs of patients. I want to make clear that while I have discussed these ideas with many stakeholders in the healthcare system, the views I share today are my own. In my opinion the current tort-based medical liability system – even after the usual reforms are implemented – does not well serve the interests of patients or healthcare professionals nor will it facilitate desirable healthcare transformation. There are better alternatives.

At a time when the viability of the current reform approach as embodied in HR 5 is being questioned, versions of which have passed the House eight times but have never passed the Senate, proponents of reform have the opportunity to reframe the debate.

Access to Medical Care

If the rationale given for medical liability reform is limited to the argument that high malpractice premiums reduce access to medical care because in one way or another medical professionals will withhold their services – by moving out of state, retiring, even choosing not to become a doctor – then the focus tends to be on the needs of the doctor. While these arguments are valid – even compelling – they have not been sufficient to create broad, bi-partisan support for reform at the national level.

Advocates for reform should put more emphasis on patient safety and put liability reform in the context of a broader agenda of healthcare transformation. What do patients and their advocates care about? What would a transformed healthcare system look like? And in what ways is the current medical liability system impeding progress toward that vision?

Successful legal reform efforts in the past have had three common elements: 1) a benefit to consumers and potential plaintiffs; 2) balance and fairness; and 3) sufficient stakeholder unity. The surprise passage of a very comprehensive Y2K Liability Act in 1999 had all of these elements – including the passionate support of the high tech industry, which is a very attractive constituency for both political parties. Successful federal medical liability reform will need those elements as well.

A New Contract with Patients

Putting more emphasis on patient safety would allow the healthcare industry and policymakers to offer a new contract with the public — "We will do all we can to reduce

the avoidable risks of medical treatment and will provide a fair, fast and accessible system to compensate patients when avoidable injuries do occur."

Without question, access is chief among patient concerns. As you know, enormous intellectual and political effort is going into making healthcare more accessible – the Medicare Drug Benefit, Healthcare Savings Accounts, CMS reimbursement policies and coverage for the uninsured, etc. The cost issues top many stakeholders' agendas.

But patients and their advocates also care about the quality of the healthcare system to which they have access. They care about improving patient safety, finding new cures for diseases, expediting drug approval, improving doctor-patient relationships and improving patient literacy.

There are many passionate advocates for adopting policies that will facilitate healthcare transformation made possible because of advances in information technology and understanding of the human genome. In a 2004 speech at the National Press Club, Senator Frist painted a compelling picture of the future healthcare system he would like to see by introducing the audience to a fictional patient from the year 2015:

> The patient, Rodney Rogers, is a 44-year-old man from the small town of Woodbury, Tennessee. He has several chronic illnesses, including diabetes, hypercholesterolemia, and hypertension. He is overweight. He quit smoking about eight years ago. His father died in his early 50s from a massive myocardial infarction. In 2005, Rodney chose a health savings account in combination with a high-deductible insurance policy for health coverage.
>
> Rodney selected his primary medical team from a variety of providers by comparing on-line their credentials, performance rankings, and pricing. Because of the widespread availability and use of reliable information, which has generated increased provider-level competition, the cost of healthcare has stabilized and in some cases has actually fallen, whereas quality and efficiency have risen. Rodney periodically accesses his multidisciplinary primary medical team using e-mail, video conferencing, and home blood monitoring. He owns his privacy-protected, electronic medical record. He also chose to have a tiny, radio-frequency computer chip implanted in his abdomen that monitors his blood chemistries and blood pressure.
>
> Rodney does an excellent job with his self-care. He takes a single pill each day that is a combination of a low dose of aspirin, an angiotensin-converting–enzyme (ACE) inhibitor, a cholesterol-lowering medication, and a medication to manage his blood sugar. That's one pill daily, not eight. He gets his routine care at his local clinic. He can usually make a same-day appointment by e-mail.
>
> Unfortunately, chest pain develops one day while Rodney is on a weekend trip several hundred miles from home. The emergency room physician quickly accesses all of Rodney's up-to-date medical information. Thanks to interoperability standards adopted by the federal government in 2008, nearly every emergency room in the United States can access Rodney's health history, with his permission. The physician diagnoses an evolving myocardial infarction by commanding Rodney's implanted computer to perform a series of rapid diagnostic tests. The cardiologist in the "nanocath" lab injects nanorobots intravenously, and remotely delivers the robots to Rodney's coronary arteries. The tiny machines locate a 90 percent lesion in the left anterior descending coronary artery and repair it.
>
> The hospital transmits the computerized information about Rodney's treatment, seamlessly and paperlessly, to Rodney's insurer for billing and payment. The insurer pays the hospital and physicians before Rodney returns home. Payments are slightly higher to this hospital than to its competitors because of its recognized high quality and performance. Rodney's hospital deductible and co-insurance are automatically withdrawn from his health savings account. Because Rodney has met

all his self-management goals this year, he gets a 10 percent discount on the hospital deductible.

Senator Frist concluded that: "Rodney's world is the future. The high-quality, rich information and common-sense efficiency inherent in Rodney's care are all within our grasp. In fact, we have seen similar and even greater transformations in equally complex sectors of our economy. It is time that healthcare follows the rest of our competitive economy and information society into the 21st century."

All those who would like to see such a system in the future should be asking whether our current tort-based medical liability system will help or hinder our efforts to achieve that vision. Or, whether politically achievable patient safety and compensation systems would better serve that vision and the interests of patients.

Problem with Current Medical Liability System

There are many problems with the current tort-based liability system which have been well-documented elsewhere.

Access/Cost:

- The current system is creating a shortage of providers.
- Fear of litigation causes physicians to practice defensive medicine.
- The current system raises healthcare costs generally, often beyond the reach of the most vulnerable.

Inefficiency:

- The current system provides inadequate compensation to injured patients.
- Injured persons face a lengthy wait before receiving compensation.
- Litigation includes high transaction costs which substantially reduce actual payments to plaintiffs.

Innovation:

- Litigation slows down the cycle of innovation and impedes the FDA approval process.
- Litigation increasingly involves layperson juries often second-guessing FDA science-based determinations.
- The current liability system has adversely impacted women's health.
- Litigation concerns cause safe and effective drugs to be withdrawn or completely withheld from the market.

Doctor-Patient Relationships:

- Inhibits communication between doctors, their patients and their colleagues.
- Litigation-related advertising causes patients to stop taking properly prescribed medicines.
- Fear of litigation causes some doctors not to prescribe medicines they believe are appropriate.

Patient Literacy:

- Litigation concerns contribute to confusing communications on drug labels, patient packet inserts and other patient information.

Use of Electronic Medical Records and Systems:

- Many doctors and hospitals fear that electronic medical records will be used as a resource for litigation by lawyers.

Misplaced Trust

My perception is that the only reason the public endures a medical liability system that contributes to so many problems is that it believes aggressive personal injury lawyers are essential to keep doctors and medical manufacturers honest. They may also believe that the medical industry has too much influence over the government bodies designed to protect the public, such as state medical boards and the FDA. The plaintiffs bar often uses those fears to justify asking their political allies to block reforms of the current tort-based medical liability system.

However, in looking at this question eSapience, a think-tank in Cambridge, Massachusetts, found there are many who question whether the current medical liability system helps or hinders patient safety. In a 1999 study the Institute of Medicine (IOM) estimated that as many as 98,000 Americans die each year as a result of preventable medical errors. Many of these deaths result from errors caused by the misuse of drugs and medical devices regulated by the FDA. The IOM and others also suggest that more than half the errors that underlie those deaths can be linked to failed systems and procedures that are poorly designed to accommodate the complexity of healthcare delivery.

Seven years later, improvements in patient safety can be seen at the margin, but much work is left to be done. Technology can pave the way toward improved patient outcomes across the healthcare delivery system. It can help healthcare providers, the FDA, and drug manufacturers navigate the complexity of the healthcare system by systematically capturing, distributing, analyzing and safeguarding the essential information needed to support decision-making. Better information can also benefit patients and their doctors by reducing avoidable medical errors and adverse events related to the administration of prescription drugs and biologics, and in some cases, accelerating the drug approval process.

Technology is an essential component of a healthcare system that has safety and patient well being as its overarching priority. Such a system must also be designed around a set of incentives for all healthcare stakeholders to contribute willingly and act upon that information. Today, the tort system is seen as an impediment to the free exchange of information related to medical errors and adverse events. The IOM has repeatedly declared that patient safety is hindered by our current system of legal liability and the overhanging threat of litigation, which discourage the disclosure of the very information that could reduce avoidable medical errors.

The current approach focuses too little on changing systems to improve patient safety and too much on punishing individuals or companies who are alleged to be at fault. The punitive nature of the tort system creates an incentive to conceal information for as long as possible if there is an allegation of injury. It also forces densely worded prescription drug labeling in an effort to cover all possible adverse outcomes, which is confusing to doctors and their patients. The tort system thwarts the important principle of shared knowledge, which makes it difficult to learn in real time from others. It was shared knowledge that dramatically cut the response time to the SARS epidemic. This principle is considered critical to the successful results of other industries where consumer safety is tantamount. The airline, nuclear energy and chemical industries, for example, all have non-punitive surveillance systems that foster the exchange of information and which is said to help these industries avert the great majority of all accidents or injuries.

As the IOM report has suggested, patient safety is also made more difficult given the sheer complexity of the healthcare system itself. The delivery of healthcare involves the careful orchestration of a dynamic network of people and processes that must work together to deliver care to patients. According to Professor James Reason, the healthcare system has more than 50 different types of medical specialties and subspecialties interacting with each other and with an equally large array of allied health professions.

Efforts to improve patient safety must, therefore, focus on what is needed to improve the inter- and intra-workings of this overall system. Prior efforts to reform patient safety and medical malpractice have focused on worthy, but narrow silos. They have not always been effective because they did not adequately address the interaction of a specific reform on the overall system.

If the IOM report is correct – that it is bad systems and not bad people or companies that led to the majority of medical errors and injury – then a piecemeal approach to reform will not create the sea-change needed to advance a national patient safety agenda. Reducing medical errors and minimizing adverse events related to the manufacture and use of prescription drugs will hinge on the design of a system that makes wrong actions by those with a stake in healthcare delivery more difficult; makes it easier for those entrusted with ensuring patient safety to discover the errors that could occur before they do; and provides patients with just compensation in the event they are injured.

It Takes a System

As the IOM found, the problem is not mistakes by doctors that cause most medical injuries, it is system errors or an absence of a system. Therefore, Congress should encourage the creation of Patient Safety and Compensation Systems at the state level where the medical liability system is seen as a component of a much larger patient safety system. These new systems would facilitate – not inhibit – positive healthcare transformation and serve the interest of all of the stakeholders in our healthcare system. The four pillars of improving the capacity and quality of our healthcare systems are Information, Infrastructure, Incentives and Innovation:

- Information is essential to improving doctor/patient decision making, reducing medical errors, minimizing redundancy, enabling research and reducing illness and disease;
- Infrastructure is essential so that information can be accurately, efficiently and confidentially captured, exchanged and efficiently analyzed;
- Incentives drive the behavior of doctors, patients, employees, insurers and manufacturers of health-related products; and
- Innovation produces new preventatives, new tools for diagnoses and new treatments for illness and disease.

National Medical Data Center

It now appears both technically and politically possible to create the capability at the national level of accessing on a real-time basis medical data (data that cannot be used to identify the patient or the healthcare professional) from an ever-increasing pool of electronic medical records. Realistically, this goal could not be achieved overnight. At the present time, only a small percentage of patients have Electronic Medical Records (EMRs). The data in those records are uneven, non-standardized and as one expert said "getting doctors to include data that is not clinically useful will be a challenge." However, there are an increasing number of efforts to mine the electronic claims data of medical insurance companies which are producing immediately useful information as well as providing signals suggesting closer scrutiny of the paper files.

Eventually these EMRs would contain sufficient standardized data (or data that could be translated to standard terms) to allow studies by government, academic and industry researchers to reach valid scientific conclusions regarding effective treatment protocols, strategies for avoiding medical errors and adverse event and promising paths in the search for cures for disease. The availability of such a database could greatly reduce the marginal cost and time needed to do valid scientific studies and could fuel a dramatic increase in effective medical research. Such a database, even as it matures, also would aid HHS, CMS, FDA, DHS and CDC in fulfilling their missions.

Experience-rated Compensation Systems

At the heart of this vision is an experience-rated administrative compensation system and trusted regulators focused on patient safety. The premise of this approach is that a compensation system with a relatively low cost of claiming for the patient will drive up the standard of care and reduce medical errors more effectively than the more random tort system. It is fairly well accepted that raising the likelihood of detection deters unwanted conduct more effectively than extreme, random and unpredictable penalties. If, as expected, the use of electronic medical records and practice aids which reduce medical errors becomes the standard of care for certain treatments, this liability system will produce powerful incentives for their adoption and help drive positive healthcare transformation.

The idea of administrative courts is not unique. Social Security, Workers Comp, the Childhood Vaccine Fund – even Bankruptcy Courts – all operate without juries and because of various features of due process have been held to be constitutional. The feature of a Patient Safety and Compensation System that makes it somewhat unique is the way in which the components would interact.

Medical Claims Facility:

If a patient – who was a resident of that state – thought that he or she had been injured as a result of medical treatment by a medical provider in that state, then the patient could contact that state's Medical Claims Facility – operated by the Medical Providers Insurance Facility comprised of insurers who write insurance for doctors, hospitals and nursing homes in that state.

Claims Assistant:

The patient would be assigned a Claims Assistant (think paralegal) who, though not an advocate for the patient, would help the claimant pull together his or her medical file, make sure the claims forms were complete and submit them to the Claims Facility Medical Staff. The same Claims Assistant would be assigned to the patient for the duration of the claims process.

Medical Staff:

The Medical Staff would notify the professional(s) involved and his or her malpractice carrier and would compare the claims forms and medical file against the practice guidelines issued by the Medical Practice Commission. The Medical Staff would make a determination whether the evidence indicated that the medical provider had met the applicable standard of care. If there were no applicable guidelines, then the Medical Staff would ask the Medical Practice Commission to analyze the facts of that particular case and issue an opinion as to whether the professional had met the applicable standard of care. The Medical Staff would also be authorized to require an independent medical exam at no expense to the patient.

Medical Providers Insurance Facility:

Once the Medical Staff concluded that the claimant should be paid, a claims processor would contact the patient and offer to settle his or her claim. If the patient agreed to settle, then the Medical Providers Insurance Facility, which would operate like a Joint Underwriting Association, would pay the claim with funds provided by the provider's malpractice insurer. Ideally, the state would not subsidize these awards.

The Medical Providers Insurance Facility, which would have an incentive to reduce medical errors and a mechanism for insurers to act collectively, would also direct loss reduction programs to reduce the number of medical errors in the state. In egregious cases, the Facility would also make referrals, along with the Administrative Medical Court to the Patient Safety Board, for possible action against the professional.

All medical providers, including nursing homes, would be required to have medical malpractice or other insurance which was experience-rated based on the providers safety record. If a provider, based on a history of malpractice claims, could no longer prove financial responsibility, it could not operate in the state.

Administrative Medical Court:

If the patient did not accept the offer, which could be governed by some form of "early offer" incentives, then he or she could ask for a hearing in front of an Administrative Medical Court Judge. The Judge could take testimony, allow discovery and otherwise conduct a civil trial. While parties could have lawyers and retain their own experts, the Judge would rely heavily on the opinion of *Daubert* qualified experts working on behalf of the State Medical Commission which would be expected to apply nationally accepted standards of care to the particular circumstances of cases that come before the Medical Practice Commission and Administrative Medical Court.

Medical Practice Commission:

The Medical Practice Commission would be appointed by the Governor and made up exclusively of *Daubert* qualified experts in medical practice. It would be essential that Commission members have the support of the medical specialty groups in the state. If a state's system handles claims against medical manufacturers, then the Commission should include *Daubert* qualified experts to make determinations whether a particular medical product or device is the likely cause of a medical injury.

Courts of Appeals:

If either party is not happy with the Medical Court's decision, then the party may appeal the decision "on the record" to whatever state courts of appeal have jurisdiction.

Patient Safety Board:

A Patient Safety Board appointed by the governor and confirmed by the legislature would have authority to order further training, suspend or revoke a medical providers license and/or impose appropriate fines. The Board would have representatives of both the professional and patient communities.

Patient Safety Data:

The whole system would rely on evidence-based medical data accumulated by government agencies, safety organizations or other credible sources including the National Medical Data Center.

State Electronic Healthcare Initiative:

A state electronic healthcare initiative involving all stakeholders would provide the leadership to set the standards, overcome silos and seek funding mechanisms to achieve adoption, interoperability and functionality for electronic medical records and electronic medical systems.

"Keep America Healthy Campaign"

The Congress and Administration, with or without legislation, could encourage public/private partnerships to encourage healthy behaviors and the creation of a culture of health. Most policymakers in and out of government focus on the cost of treatment side of the healthcare cost equation where "cost equals incidences of disease times cost of treatment." It is time for America to focus more attention on lowering the incidences of disease. While there are many community and corporate disease prevention programs being undertaken already, a concerted effort that more effectively organizes and mobilizes our national resources would have a better chance of changing behavior and

positively affecting culture. Lady Byrd Johnson's "Keep America Beautiful Campaign" dramatically reduced the incidence of roadside litter. A "Keep America Healthy Campaign" would do the same for the incidence of debilitating and costly diseases.

Federal Legislation

To encourage the creation of Patient Safety and Compensation Systems along the lines outlined, Congress has many choices about how best to provide leadership and incentives. There are substantial Federal interests to justify taking action including the Medicare and Medicaid programs, the Medicare Drug Benefit, the interstate nature of the healthcare and health insurance industry and the interstate nature of large employers for whom these reforms could be critical in saving American jobs. Therefore, I urge Congress to consider legislation that deals with the issues discussed.

Patient and Safety and Compensation Act
(A Legislative Concept)

Title I – National Medical Data Center

The National Medical Data Center would make available to authorized users the real-time, privacy-protected data from as many as 12 million electronic medical records nationwide.

Title II – Electronic Health Initiative

The Act could create national uniform standards as needed to facilitate and provide formula grant funding and technical assistance to the States for electronic health systems to improve patient safety, lower costs and improve medical care. Formula grants would be subject to certain conditions and criteria to ensure the funds are put to their intended use.

Title III – Uniform State Medical Liability Standards

This title would contain politically achievable Federal preemptive standards in recognition of the fact that state healthcare liability systems do have a substantial impact on interstate commerce and that national healthcare transformation can be impeded by a single state legal system that imposes unreasonable and damaging liability standards on a national market for medical services and products.

The items that follow have been suggested as belonging in any new Medical Liability Reform (MLR) legislation. They are listed here as placeholders only, and there may be some items on the list that should be deleted/modified; there may be some "missing" items that need to be added.

- Federal standards for medical liability litigation in federal or state court
- Scope of bill's application (persons/entities; definitions)
- Scope of legislation – ERISA and related issues
- Speedy resolution of claims through statute of limitations changes
- Limits on non-economic damages or keep existing state limits
- Damages apportioned by "fair share" rule, i.e., no joint and several liability
- Limits on attorney contingency fees
- Standards for "expert witnesses"
- Use of Medical Screening Boards/Panels
- Adoption of "I'm Sorry" programs
- Independent External Medical Review
- Reduction in awards for collateral sources
- Limits on and/or standards for punitive damages
- Periodic (not lump sum) payments (use federal standards to comply)

Title IV – Alternative State Medical Liability Systems

Title IV would encourage and facilitate the creation of new healthcare liability systems that are patient safety focused along the lines of the Patient Safety and Compensation System. It would provide incentives and guidelines for states to create demonstration programs to test alternatives to current medical tort litigation. Funding to states under this title would cover planning grants for the development of proposals for alternatives, and would also include the initial costs of getting those alternatives up and running. The legislation also would require participating states and the federal government to collaborate in continuous evaluations of the results of the alternatives as compared to traditional tort litigation.

Conclusion

This holistic approach to healthcare allows focus on three key goals:

- More effective prevention of illness and disease;
- Early diagnosis; and
- More efficient and effective treatment.

The goal of the Patient Safety and Compensation Act would be to provide the leadership and expertise needed to overcome inertia and move the country toward a shared vision of a transformed healthcare system. It also recognizes that legal reform is a critical step on that path. To pass this legislation and indeed to achieve the broader goals of healthcare transformation will require bipartisan cooperation and a coordinated effort with employers, health insurers, medical professionals, and medical manufacturers working collaboratively with patient and consumer groups.

It is reasonable to conclude that widespread adoption of some version of this systematic approach to medical liability and the electronic medical systems that facilitate patient safety could save the country $114 billion or more out of the $1.6 trillion currently spent annually on healthcare. According to a January 2005 article in the Journal of Health Affairs, savings could be as much as:

$ 78 Billion for delivery and administration
$ 29 Billion for avoidable medical errors
$ 7 Billion for non-meritorious legal actions
$114 Billion

Most importantly, the article also predicted a reduction in medical errors which could save over 7,000 lives a year.

An initiative of this scope will require Congressional leadership. Only Congress can insist on stakeholders working together to work out their differences, encourage the compromises that allow progress toward a common goal and enforce the discipline that prevents " freelance" lobbying from killing such an important legislative initiative. Again, Mr. Chairman, thank you for the opportunity to share my perception on these issues, and I look forward to any questions you or your colleagues may have.

MR. DEAL. Thank you.

Mr. Barringer.

MR. BARRINGER. Thank you. Good morning, Chairman Deal and members of the committee. Thank you for inviting me to be here today.

My name is Paul Barringer, and I am the General Counsel of Common Good, which is a bipartisan legal reform coalition. We very much applaud the committee for its vision and leadership in convening

this morning's hearing to consider innovative solutions to problems in America's ailing medical liability system.

Personally, I am really honored to have this opportunity to share information with you today about the work that our organization has been doing to promote the concept of health courts or special courts to handle medical injury cases.

With the support of the Robert Wood Johnson Foundation, we have been working with the research team from the Harvard School of Public Health, which includes Professor Mello and her colleague, David Studdert, to develop the conceptual framework for administrative health courts and to cultivate support from key stakeholders for demonstration projects that could be done to test the feasibility of this proposal.

The context within which this proposal arises is, as Professor Mello and Mr. Wootton have detailed, in existing medical injury dispute resolution and compensation system, which does not work as well as it could. We know that few injured patients receive compensation. We know the system is very inefficient and contributes to escalating costs. We know it has adverse impacts on the relationship between physicians and their patients. Perhaps most significantly, as the Institute of Medicine and many others have observed, the system functions as a major impediment to efforts to enhance patients' safety and improve quality largely due to the strong disincentives it provides to candor about errors that have occurred in treatment.

There is an urgent need for new and innovative solutions in the area of medical liability, and fortunately, there are promising new models that can help, such as the health court model that we have developed.

Generally, the system we propose is one that would rely to a much greater extent than the existing system on administrative processes for determining liability and compensation. There are a couple key reasons for this, including a greater efficiency associated with administrative compensation systems, the opportunity to expedite proceedings and get compensation awarded to those who have been injured much more rapidly, and also a potential for greater consistency and reliability in verdicts.

I would note that the system we proposed is very much like the patient-centered, safety-focused proposal advanced by the Institute of Medicine in its 2002 report around demonstration projects across the healthcare system.

In particular, we envision an administrative system with strong early disclosure and offer programs at the institutional level, say at the hospital or integrated delivery system or perhaps the liability insurer, which we modeled on programs that have been implemented successfully around the country, such as those at the Veterans Administration, hospitals, the

University of Michigan health system, and also at the COPIC Insurance Company in Colorado. We also envision reliance in these programs on so-called accelerated compensation events or commonly occurring injuries for which compensation can be rapidly paid.

If the early disclosure and offer process fail to satisfy either party, we would see the matter transferred to the health court where you would have judges with training and expertise in healthcare relying on mutual expert witnesses retained and compensated by the court to make decisions about the standard of care in injury cases. Health court judges would issue written rulings of their decisions that would provide guidance in future cases, and these judges and experts would also rely on evidence-based standards of practice, such as those disseminated by the National Guideline Clearinghouse at the Agency for Healthcare Research and Quality, as well as other organizations.

Significantly, we see decision-making in the proposed system as relying on a standard of liability other than negligence, which is what we use in today's system. We see particular promise with the standard employed in several Scandinavian countries, which is known as "avoidability." Under the avoidability standard, which is broader than negligence, those adverse consequences of treatment that could have been prevented or avoided had best practices been followed, are compensable. The aim of the avoidability standard is to expand compensation to injured patients and also to reduce emphasis on blaming the individual providers. This is appropriate, because most experts agree that errors, generally, result not from individual malfeasance, but rather from breakdowns in systems of care at the institutional level. The avoidability standard is one which recognizes this role that systems play in leading to errors.

Finally, I would note that the system we envision would have a range of linkages to patients, safety structures, and initiatives so that we could learn from our mistakes and help prevent mistakes from occurring in the future.

We have been very gratified to find the health court proposal drawing support from a wide array of stakeholders, including patient safety advocates, consumer groups, public health and legal experts, the national and regional press, and healthcare provider groups. We have also been very pleased and excited that there have been several bills proposed in Congress that would create health court pilot projects at the State level.

We hope that Congress will take speedy action with respect to one or more of these proposals, and once more, we appreciate this opportunity to provide information today.

Thank you.

[The prepared statement of Paul Barringer follows:]

PREPARED STATEMENT OF PAUL BARRINGER, GENERAL COUNSEL, COMMON GOOD

Thank you for this opportunity to discuss innovative approaches to improving America's medical liability system.

I appear as General Counsel of Common Good, a legal reform coalition. We are a bipartisan organization – former Senators Howard Baker and Bill Bradley are members of our Advisory Board, as are former Senator George McGovern and Representative Newt Gingrich – funded primarily by philanthropic foundations. Our largest financial supporter is the Robert Wood Johnson Foundation, which is currently underwriting a two-year collaborative effort between our organization and the Harvard School of Public Health to refine a conceptual proposal for developing specialized health courts to resolve medical injury disputes. Common Good has been active nationally since 2002 in promoting the development of specialized health courts.

The debate over medical malpractice reform remains one of the most polarized in American politics. Frequently lost in partisan disagreements, however, is this key fact: America's approach to resolving medical injury disputes works poorly for consumers and health care providers. Many preventable injuries occur today in the course of health care treatment, yet few injured patients file a claim. Even fewer receive any compensation, and those who do never see the full award. When attorney fees and other administrative costs are included, only 46 cents of every dollar spent in tort cases in 2003 reached injured claimants.[1]

The system also fails health care providers. In particular, today's system does a poor job in distinguishing negligent from non-negligent care, providing ambiguous signals to health care providers about what it will take to avoid litigation, and encouraging costly "defensive medicine."[2] Moreover, the system discourages providers from disclosing information about errors or "near misses" (those errors that do not result in any harm).[3] This is unfortunate, as patient safety experts identify such reporting as a key element in comprehensive efforts to improve quality in the health care system. This chilling effect on information disclosure has led the Institute of Medicine (IOM) and others to identify the existing legal system as a major impediment to system-wide patient safety enhancements.[4,5]

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[1] *U.S. Tort Costs: 2003 Updat*e 17 (Tillinghast-Towers Perrin 2003).

[2] For example, one out of four baseless claims result in payment, according a recent study by Harvard School of Public Health researchers. See David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, New England Journal of Medicine, vol. 354; May 2006, p. 2029. For information about defensive medicine, see, e.g., Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?* May 1996 *Quarterly Journal of Economics* 353-390. It is important to note that there are substantial variances in estimates of what defensive medicine costs the U.S. health care system. The article cited above represents perhaps the highest estimate, although the validity of this estimate has been challenged. There is little question, however, that defensive medicine does in fact occur. See e.g., David M. Studdert, Michelle M. Mello, William M. Sage, Catherine M. DesRoches, Jordon Peugh, Kinga Zapert, & Troyen A. Brennan, *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment* 293 Journal of the American Medical Association 2609-2617 (2005).

[3] *Crossing the Quality Chasm: A New Health System for the 21st Century*, Institute of Medicine 219 (National Academies Press 2001).

[4] *Crossing the Quality Chasm: A New Health System for the 21st Century*, Institute of Medicine 219 (National Academies Press 2001).

[5] *Health Care At The Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury* 27 (Joint Commission on the Accreditation of Healthcare Organizations 2005).

Since the late 1990s, the concepts of patient safety and health care quality have become increasingly important drivers in health policy. Perhaps no single event galvanized public interest in safety and quality more than the IOM's 1999 publication of *To Err is Human: Building a Safer Health System.*[6] In this landmark report, the IOM revealed that as many as 98,000 people die unnecessarily every year in American hospitals because of medical errors. The report concluded that most errors are caused not by individual providers but rather by breakdowns in larger systems of care.[7] This report stimulated significant political interest in safety and quality, and has led to the development and introduction of numerous legislative initiatives to address these issues.[8]

As interest in patient safety has increased, so too has the awareness that health care quality and the medical malpractice system are connected. To better prevent medical errors, experts say, more information needs to be disclosed about errors and near misses.[9] Only with such data can hospitals and providers analyze the patterns and frequency of medical error and focus on fixing the system-wide breakdowns that lead to errors. However, fear of litigation in the current system impedes the open exchange of information about errors and near misses. Significantly, the IOM identified the legal system as a major impediment to improved quality in a 2002 report titled, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*. "There is widespread agreement," the report stated, "that the current system of tort liability is a poor way to prevent and redress injury resulting from medical error."[10] The report called on Congress to charter demonstration projects to explore new ways to resolve medical injury cases.

Growing out of the IOM's recommendations, support has continued to increase for experimenting with new approaches to resolving medical malpractice disputes, including the development of specialized health courts. Common Good, founded and chaired by attorney and author Philip K. Howard, has been the leading proponent of the health court concept and, as stated previously, has been working with the Harvard School of Public Health to refine the health court concept and cultivate stakeholder support.[11]

As currently envisioned,[12] the health court concept includes the following elements: trained judges relying on neutral experts to adjudicate malpractice disputes; reliance on a new standard of liability – "avoidability" – that is broader than negligence; explicit use of evidence-based guidelines to aid decision-making; damage schedules for compensating injured claimants; and a range of linkages to patient safety structures and initiatives. Generally, the proposed system would rely to a much greater extent than the current system on administrative processes for determining liability and compensation. Key reasons for this include the greater efficiency associated with administrative

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[6] *To Err is Human: Building a Safer Health System*, Institute of Medicine (Linda T. Kohn, Janet M. Corrigan, & Molla S. Donaldson eds., National Academies Press 2000).

[7] *To Err is Human: Building a Safer Health System*, Institute of Medicine 1 (Linda T. Kohn, Janet M. Corrigan, & Molla S. Donaldson eds., National Academies Press 2000).

[8] See, e.g., The Patient Safety and Quality Improvement Act of 2005, P.L. 109-41, signed into law July 29, 2005.

[9] *Crossing the Quality Chasm: A New Health System for the 21st Century*, Institute of Medicine 219 (National Academies Press 2001).

[10] *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*, Institute of Medicine 82 (Janet M. Corrigan, Ann Greiner, & Shari M. Erickson eds., National Academies Press 2002).

[11] *Harvard School of Public Health and Common Good to Develop New Medical Injury Compensation System*, Harvard School of Public Health Press Release, January 10, 2005. http://www.hsph.harvard.edu/press/releases/press001102005A.html.html

[12] More information about the evolving health court proposal is available at http://cgood.org/healthcare.html.

compensation systems as well as their ability to award compensation to injured claimants more rapidly.[13,14]

A core element of the health court concept is that health court judges should have expertise in medical issues. Judges would be selected through an independent and nonpartisan screening process, and sitting judges would participate in additional training and education to ensure their continued understanding of the evolving issues in health care. These judges would make decisions about proper standards of care, and would issue written rulings of these decisions, which would provide guidance for future cases and in turn would help promote consistency from case to case. Over time a body of law would develop that would differentiate between what is good medical practice and what falls short, and this would send clear and consistent signals to health care providers.[15] By concretely defining and promoting consistent standards, this process could also help reduce variations in medical practice patterns across populations and geographic areas, and improve standards of care both regionally and nationally. It could also help reduce costly defensive practices, and more broadly provide a framework for cost-containment.

A record of these decisions and other de-identified data from claims would be reported to patient safety authorities (and back to providers) for root cause analyses of what went wrong and why. Standardized event reporting would ensure that the appropriate information is reported. In the aggregate, such data would also help facilitate epidemiological analyses for purposes of developing health quality improvement initiatives and preventive practices.

As we envision it, compensation decisions in a health court system would be based on a standard other than negligence. Health care treatment is considered "negligent" today if the provider failed to exercise the level of care that a reasonable person would have exercised in the same circumstances. Many experts have identified the negligence standard as contributing to an overemphasis on blaming providers for adverse events that have occurred in treatment. This is inappropriate, studies suggest, because most errors result not from individual malfeasance but rather due to breakdowns in systems of care.[16]

Of particular promise moving forward is the concept of "avoidability," which is employed in Scandinavia. Under this approach, a medical injury is deemed compensable if it could have been prevented (or "avoided") had the doctor followed the best medical practice – whether or not the treatment was negligent. Although avoidability is broader than negligence as a theory of liability, it does not constitute absolute or strict liability for every bad outcome. Only those injuries which are caused by treatment and which could have been prevented (avoided) are eligible for compensation.[17]

Use of the liberalized avoidability standard of recovery would likely help expand the number of patients who receive compensation. Application of the avoidability standard should also help lessen the emphasis on blaming individual providers. Unlike a negligent event, an avoidable event does not necessarily implicate blame on the provider involved (since even the best provider can experience an avoidable event). In Denmark and

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[13] Randall R. Bovbjerg, Frank A. Sloan, & Peter J. Rankin, *Administrative Performance of "No-Fault" Compensation for Medical Injury*, 60(2) Law and Contemporary Problems 71, 90-98 (1997).

[14] David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286(2) Journal of the American Medical Association 217, 219 (2001).

[15] Note that appeals to resolve disputes about the standard of care within and across state lines could be made to a dedicated court of medical appeals, potentially at the federal level. Similar to the current system, both parties would have lawyers representing them.

[16] *To Err is Human: Building a Safer Health System*, Institute of Medicine 51 (Linda T. Kohn, Janet M. Corrigan, & Molla S. Donaldson eds., National Academies Press 2000).

[17] David M. Studdert, E.J. Thomas, B.I. Zhar, J.P. Newhouse, P.C. Weiler, & Troyen A. Brennan, *Can the United States Afford a 'No-Fault' System of Compensation for Medical Injury?*, 60(2) Law & Contemporary Problems 1, 3-7 (1997).

Sweden, use of the avoidability standard has helped create a much less combative and litigious environment between physicians and patients, and has helped provide an incentive for providers to help their patients with the claims process and ensure that they receive appropriate compensation for avoidable injuries.[18]

In today's medical malpractice system, each party typically retains its own expert witnesses. These competing experts-for-hire often provide distorted or conflicting advice that can confuse juries and add time and expense to the process by which disputes are resolved. Under the health court approach, by contrast, health court judges would consult with neutral medical experts to determine the standard of care in medical injury cases. These expert witnesses would be compensated by the court, and they could be held accountable to a standard of objectivity by regulatory authorities.

Of course, determining the appropriate standard of care in a specific case can be a complex undertaking, regardless of the expertise of the decision-maker. Also, there may be several reasonable courses of treatment in a particular circumstance. To aid health court judges in reaching consistent decisions from case to case, judges would consult clinical practice guidelines based on evidence-based practice standards, such as those published and disseminated by the National Guideline Clearinghouse at the U.S. Agency for Healthcare Research and Quality, or by medical specialty organizations.[19]

Based on reviews of the best available scientific evidence about how adverse events occur and the extent to which they are preventable, medical experts and key stakeholders could also work together to develop compensability recommendations for health court judges to apply, including the development of so-called "avoidable classes of events" or "ACEs" (predetermined malpractice scenarios that have been compiled by experts to expedite the claims process in clear-cut cases).[20,21] Clear-cut cases would be fast-tracked for compensation, and efforts would be made to encourage early offers of compensation. In particular, claims against institutional health care providers (such as a hospital or integrated delivery system) would begin with consideration of the claim internally by a review board associated with the clinical enterprise. In clear and uncontestable cases, the review board would designate the injury as an ACE, and the provider would be ordered to pay damages according to the appropriate compensation schedule. In cases in which the circumstances of injury were not straightforward, the case would be referred to a health court.

In today's system, few injured patients are compensated and there is little consistency in awards from case to case. To promote horizontal equity, the health court system would have a schedule of benefits specifying a range of values for specific types of injuries and taking into account patient circumstances. To ensure fairness, this compensation schedule could be set by an independent body and periodically updated. Individual awards would likely be smaller on average than the awards in the current system, but having compensation schedules would ensure that more plaintiffs had access to reasonable compensation. At the same time, use of a compensation schedule could help reduce the percentage of total system costs devoted to administrative expenses. Comparable administrative compensation systems in the U.S. and overseas devote far

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[18] *Administrative Approaches to Compensating for Medical Injury: National and International Perspectives*, Event Transcript 16, 22, Public Forum held by Common Good-Harvard School of Public Health at Carnegie Endowment for International Peace, Washington, D.C., October 31, 2005.

[19] National Guideline Clearinghouse, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, http://www.guideline.gov/.

[20] Randall R. Bovbjerg, Laurence R. Tancredi, & Daniel S. Gaylin, *Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System*, 265(21) Journal of the American Medical Association 2836-2843 (1991).

[21] Randall R. Bovbjerg & Laurence R. Tancredi. *Rethinking responsibility for patient injury: accelerated-compensation events, a malpractice and quality reform ripe for a test*, 54(1-2) Law & Contemporary Problems 147-177 (1991).

less to administrative expenses than the existing tort system.[22] Research with respect to Colorado and Utah claims has indicated that a patient compensation system employing compensation schedules and an avoidability standard of liability could be implemented in the U.S. at a total system cost comparable to that of the existing system, while compensating far more patients.[23]

The health court concept calls for replacing the jury with a judicial decision-maker. The constitutional authority to create an administrative compensation system in place of a traditional jury trial is clear where it is part of a regulatory plan to improve health care.[24] Congress has broad powers to authorize pilot projects for specialized health tribunals under the Spending Clause,[25] and under the Commerce Clause because medical injury litigation is economic activity that itself constitutes, and affects, interstate commerce.[26] Contrary state law provisions, if any, would be pre-empted under the Supremacy Clause.[27] Moreover, similar federal administrative compensation systems have been upheld against constitutional challenge.[28]

A number of prominent public health experts and scholars have expressed support for the health court concept,[29] as have numerous political leaders and institutions from both sides of the aisle. For example, the Progressive Policy Institute, a Democratic think tank known in the 1990s as President Clinton's ''idea mill,'' has endorsed the concept, as has the Manhattan Institute, a conservative-leaning think tank. Numerous health care groups have expressed support as well, including the Joint Commission on Accreditation

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[22] See, e.g., Randall R. Bovbjerg, Frank A. Sloan, & Peter J. Rankin, *Administrative Performance of "No-Fault" Compensation for Medical Injury*, 60(2) Law and Contemporary Problems 71, 90-98 (1997). *Administrative Approaches to Compensating for Medical Injury: National and International Perspectives*, Event transcript 21, Public Forum held by Common Good-Harvard School of Public Health at Carnegie Endowment for International Peace, Washington, D.C., October 31, 2005.

[23] David M. Studdert, Eric J. Thomas, Helen R. Burstin, Brett I.W. Zbar, E. John Orav, & Troyen A. Brennan, *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38(3) Medical Care 250-260 (2000).

[24] As part of Common Good's ongoing Robert Wood Johnson Foundation project, Professor E. Don Elliott of the Yale Law School has developed the constitutional analysis on which this section is based.

[25] For example, see *South Dakota v. Dole*, 483 U.S. 203 (1987), upholding the federal government's conditioning state receipt of federal highway funds on adopting a drinking age of 21.

[26] See *Gonzales v. Raich*, 125 S.Ct. 2195 (2005); *United States v. Lopez*, 514 U.S. 549 (1995).

[27] See *Silkwood v. Kerr-McGee Corp*., 464 U.S. 238 (1984); *Pennsylvania v. Nelson*, 350 U.S. 497 (1956). Note that whether or not a state could assign malpractice claims to an administrative entity without violating 7th Amendment rights to a jury trial would depend in part on whether the Supreme Court would characterize the rights at issue as "private" or "public" rights. Essentially, private rights involve the obligations of one individual to another, whereas public rights involve issues relating to broad public purposes. Significantly, the Supreme Court has held that disputes implicating public rights can be adjudicated without jury trials. For example, in *Thomas v. Union Carbide Agricultural Prod. Co*., 473 U.S. 568 (1985), the Supreme Court rejected Union Carbide's right to sue for violations of trade secrets, and upheld Congress' establishment of an administrative process for registering pesticides as part of a comprehensive re-working of federal pesticide law. By this rationale, an administrative approach to resolving malpractice disputes should be constitutional if health courts are created as part of a comprehensive regulatory scheme for reforming the health care system. See, for example, *New York Central RR v. White*, 243 U.S. 188 (1917).

[28] *Colaio v. Feinberg*, 262 F. Supp. 2d 273 (S.D.N.Y. 2003), *aff'd Schneider v. Feinberg*, 345 F.3d 135 (2d Cir. 2003).

[29] Among these experts and academics are Peggy O'Kane, President of National Committee on Quality Assurance; Ken Kizer, former President of the National Quality Forum; Helen Darling, President of the National Business Group on Health; Troyen Brennan, former President of the Brigham & Women's Hospital in Boston and Professor at the Harvard School of Public Health; and William Brody, President of Johns Hopkins University. More information can be found at http://cgood.org/brochure-hcare.html.

of Healthcare Organizations, the American Association of Retired Persons, and many state and national medical groups.

The health court concept has also garnered significant media coverage and endorsements. Scores of newspaper and magazine articles have devoted attention to the concept, and a number of prominent media outlets have expressed their support. In July 2005, for example, *USA Today* opined that "'Health courts' offer cure." The opinion piece went on to say that "[h]ealth courts could show the way for quicker and fairer compensation to the deserving, and they might reduce the incentive for doctors to engage in defensive medicine. … Starting the experiment is the right medicine for an ailing system."[30] *The Economist* has called the health court concept "a sensible idea" that "ought to make the system less capricious."[31] And *The New York Times* has urged Congress to "push for a wide range of demonstration projects" for new malpractice reform alternatives, including health courts.[32]

Several bills have been introduced in Congress to create health court pilot projects. In the House of Representatives, Representative Mac Thornberry (R-TX) has introduced legislation to test new model health care tribunals at the state level.[33] In the Senate, Senator Max Baucus (D-MT) and Senator Michael Enzi (R-WY), Chairman of the Senate Committee on Health, Education, Labor, and Pensions, have introduced a bill to facilitate state level experimentation with a number of alternatives to current medical malpractice litigation, including health courts, early offer programs, and scheduled compensation.[34] Hearings were recently held to consider this legislation. Senator John Cornyn (R-TX) is expected to introduce legislation shortly as well. Finally, legislation to create health courts (or explore the feasibility of creating health courts) has been introduced in a number of states, including Illinois, Maryland, New Jersey, Pennsylvania, and Virginia, and additional state legislative activity is expected this year and next.

The debate over medical malpractice reform will almost certainly continue to be a very polarized one. As awareness continues to grow about the ways in which the current system fails patients and providers, however, support will likely continue to increase for exploring new alternatives that can benefit consumers, provide relief to providers, and help advance – rather than impede – quality improvement in health care. An administrative health court system represents a promising approach to compensating injured patients and establishing greater reliability in medical justice. With public support and political leadership, this new approach to medical justice can become a reality, both through pilot projects and as part of broader system reforms.

Thank you.

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[30] *Health Courts offer cure*, USA Today, July 4, 2005, Editorials/Opinion.
[31] *Scalpel, Scissors, Lawyer*, The Economist, December 14, 2005, Opinion.
[32] *It's Time to Try Special Health Courts*, The New York Times, January 9, 2005, Editorial.
[33] H.R. 1546, 109th Congress, 1st Sess. (2005).
[34] S. 1337, 109th Congress, 1st Sess. (2005).

MR. DEAL. Thank you.

Ms. VanAmringe.

MS. VANAMRINGE. Thank you. We appreciate the opportunity to be here today.

In early 2005, the Joint Commission issued a White Paper entitled "Healthcare at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury." This paper was developed with the assistance of a panel of outside experts with broad-based knowledge in medical liability and patient safety issues. The experts were asked to assess the performance in the current medical liability system in meeting its goals for deterring medical negligence, compensating patients, and exacting corrective justice. They were also asked to address the extent to which the current medical malpractice system supports or interferes with patient safety.

A fundamental finding of the report was that there is an empirically proven disconnect between negligence and litigation. The medical liability system is inconsistent in determining negligence and compensating patients. Few injured patients receive compensation, and those who do, are often not the victims of negligence. Recompense is highly variable for similar injuries, it is expensive to litigate, and compensation does not come quickly when it happens. What we have is a system that is not fair, not efficient, and not predictable. No one is well served.

The Joint Commission report contained over a dozen recommendations. A few recommendations appropriately called for government action. I would like to highlight some of those today.

First, let me state that the context for the recommendations in this report was considered unique when it was issued, because it recognized that there is an inextricable link between improving patient safety and liability reform. It recognizes that the increasing tension between the patient safety movement in the liability system greatly affects the quality and safety of care. On one hand, there is the growing knowledge base held by safety experts that support open communication in a blame-free environment, opportunities for learning from mistakes, and a systems approach to reducing patient risks. Distinction in the medical liability system is characterized by blame, secrecy, and adversity.

The medical liability system can have a chilling effect on the patient-provider relationship, leading to the practice of defensive medicine that exposes patients to additional risks and could force valuable information about adverse events underground, thereby perpetuating the recurrence of preventable adverse events. The crafters of the report understood that these two antithetical forces need to be harmonized. The report, therefore, is an attempt to broaden the scope of the dialogue for medical

liability reform and begin to address some of the dysfunctions that both systems experience.

The first of the three strategies in the report is to pursue patient safety initiatives that prevent medical injury from happening at the front end of the liability process. The healthcare industry has embraced the safety efforts of other industries, such as manufacturing and aviation, but it has not been able to fully emulate their successes. A recommendation, therefore, is to spur commitments to patient safety improvements, such as systems recognizing the use of information technology, the adoption of a culture of safety through the use of pay-for-performance programs. Major opportunity is presented by pay-for-performance, because it envisions rewards for achieving desired behaviors and outcomes, and it can be a very powerful tool to accomplish behavior change.

Pay-for-performance can also be used to promote another safety recommendation from the report, which is to accelerate enhanced clinical practice guidelines. Studies have documented that compliance with guidelines to improve quality, but will also reduce the risk of liability for practitioners. We also need to encourage team approaches to delivery of care. Teamwork has been found to increase the accuracy of care and to reduce breakdowns of communication, which is one of the leading causes of serious adverse events. Therefore, these and other safety improvements should be incorporated in any national design and implementation of pay-for-performance programs.

The second approach is promoting open communication. Our society values open communication between patients and their practitioners as a way to achieve high quality and safe care. But increasingly, there is a code of silence when an unexpected and serious adverse event occurs. This extends to silence between practitioners and patients, between practitioners and their peers, between practitioners and the organizations in which they practice, and between healthcare organizations and oversight bodies. In addition, silence is amplified by fears of loss of reputation or income.

The report identified two areas in which legislation could help. The first has been accomplished through the passage of the patient safety legislation, and we would like to thank this committee for its leadership. It is a landmark piece of legislation that will help us reduce errors.

The second legislative area is to produce legislation that protects disclosure and apology from being used as evidence against providers in litigation in which evidence that years of extensive and painful litigation ensue when many families and patients are only looking for empathy and seeking answers.

The last set of recommendations was structured around a strategy to create an injury compensation system that is patient-centered and serves

the common good. We have heard lots of ideas today. Many more came from our report and from others that are out there. Our final recommendation, therefore, is to encourage Congress to evaluate demonstration projects in the States in order to better understand how these will work in the real world and how they can achieve a liability system that is more efficient and equitable.

Thank you.

[The prepared statement of Margaret VanAmringe follows:]

PREPARED STATEMENT OF MARGARET VANAMRINGE, VICE PRESIDENT, PUBLIC POLICY AND GOVERNMENT RELATIONS, JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS

I am Margaret VanAmringe, Vice President for Public Policy and Government Relations of the Joint Commission on Accreditation of Healthcare Organizations. I appreciate the opportunity to testify on finding innovative solutions for our nation's medical liability system. Founded in 1951, the Joint Commission is the nation's oldest and largest standard setting and accrediting body in health care. The Joint Commission accredits approximately 15,000 health care facilities along the entire spectrum of health care services. Our mission is to continuously improve the safety and quality of care provided to the public. We are here today as an independent voice that is derived from both the multitude of expert opinion that we bring together on tough issues facing the health care system, and from our more than 50 years gathering daily information on quality and safety from the front lines of medical care delivery.

On behalf of the Joint Commission, I would like to take this opportunity to thank the Committee members for their hard work in passing *The Patient Safety and Quality Improvement Act of 2005.* When implemented, this landmark patient safety legislation will provide the cornerstone for effective reporting systems that assure confidentiality and encourage the sharing of lessons learned from the analysis of adverse events. Without surfacing richer information about the types and causes of medical errors, we will continue to experience preventable errors at unacceptable rates. Patient safety depends upon transparency of information as the basis for improvement and behavior change. This dependency creates a fundamental dissonance with the current medical liability system that drives too much of that information underground. As a result, neither patients nor providers benefit.

Background

Many proposals for solving medical liability fail patients because they do not effectively deter the underlying causes of the harm, such as medical errors. While in isolation these liability reform efforts may be helpful to some degree, there is an inextricable nexus between addressing patient safety issues and addressing medical liability reform that must be recognized. Consequently, it is essential to structure solutions to medical liability issues that do not address just the back end, but that also take into account the factors that lead to litigation and defensive medicine on the front end. By maintaining a dual focus on both safety and liability concerns, there is an opportunity to strengthen patient-provider relationships, restore trust between the affected parties, and change the way care is delivered.

This interrelationship between patient safety and medical liability concerns led the Joint Commission to convene a roundtable of 29 experts representing a wide array of interests relevant to medical liability and tort reform. The discussions and intense deliberations from the roundtable resulted in the 2005 publication of a White Paper,

"Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury." This paper, which contained over a dozen recommendations, was a call to action for those who influence, develop, or carry out policies that can lead to ways to address the medical liability system, while developing an environment that focuses on patient safety. My testimony today will highlight some of the recommendations from the White Paper that, if addressed, would move toward a medical liability system and a health care delivery system that both meet the needs of providers and patients.

Need for Comprehensive Reform

Much has been written about the effects that rising medical malpractice premiums have had on the ability of health care providers to stay in practice and provide access to certain high risk services. It is estimated that each year $28 billion is spent on medical liability litigation and defensive medicine combined.[1] On average, a medical liability case takes three to five years to come to closure.[2] Statistics suggest a strong likelihood that every surgeon will be named in a suit during his/her career. These are staggeringly true estimations of the magnitude of the problem, but they are also illustrative of the dysfunction in the medical and legal "systems." In fact, the current medical liability "system" is really not a system, but rather, a patchwork of disjointed and inconsistent decisions that has limited ability to inform the development of improved health care practices.

A number of studies have revealed the inconsistency of the medical liability system in determining negligence and compensating patients. We know that there are large numbers of preventable medical errors but only about two to three percent of negligent injuries result in a claim, and even fewer receive compensation for their injuries.[3] Conversely, only about 17 percent of claims actually involve negligent injury. This means that few injured patients receive compensation through the medical liability system, and that those who do get compensated are often not the victims of negligence. Further, compensated individuals receive highly variable recompense for similar injuries. What we have today is a system out-of-balance and lacking equity for its participants. In other words, we have a system that is not fair, not efficient, and not predictable.

Solving the rising cost of malpractice premiums will make things better but it will not result in an effective tort system or improved patient safety. Because what goes on in the court room and what goes on in our hospitals and other venues of care have become inextricably tied together, only a comprehensive approach to tort reform can alter the unfairness it imposes on patients and health care providers, and can lessen the deleterious impact it has on patient safety.

Recommendations for Consideration

The Joint Commission's 2005 White Paper contained recommendations organized around three strategies for improving the medical liability system while preventing patient injury. The recommendations that came from the expert panel are characterized as ones that would:

- pursue patient safety initiatives to prevent medical injury
- promote open communication between patients and practitioners, and

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[1] Iglehart, John, "The malpractice morass: Symbol of societal conflict," Health Affairs, July/August 2004.

[2] General Accounting Office, "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates," GAO- 03-702, July 2003

[3] Studdert, David M., Mello, Michelle M., Brennan, Troyen A., "Medical malpractice," NEJM 350;3, January 15, 2004

- create an injury compensation system that is patient-centered and serves the common good

In this testimony, we would like to mention a few of the specific recommendations in each category that may be of interest to Congress.

I. Pursuing Patient Safety Initiatives to Prevent Medical Injury

Despite the lapse of six years since the IOM's seminal report on medical error, "To Err is Human," medical error remains ubiquitous in health care delivery. Progress has been made, but the health care industry has not been able to emulate the safety successes of other industries, such as aviation and manufacturing, which rely heavily on near-miss and error reporting to "learn from mistakes. A significant problem rests is the failure of many health care organizations and institutions to adopt a culture of safety and commit to systems redesign where necessary. There are substantial costs –both direct and opportunity costs – for health care organizations that make safety a precondition for all other priorities. These costs include performing "failure mode and effects analyses" on all high risk processes of care within the organization; establishing redundant systems to guard against human factors that contribute to errors; conducting organization-wide training and education; and investing in specific information technology to reduce the likelihood of preventable error. Further, leaders of health care organizations need to "buy-into" the benefits that will accrue to them and to patients if they make these investments.

Recently, the Congress, CMS, and other national stakeholders, such as the Joint Commission, have been working on efforts to align payment with improvements in patient safety and health care quality. We believe that these efforts, sometimes called Pay-for-Performance (P4P), have the potential to encourage health care organizations to acculturate patient safety and systems re-engineering with the goal of reducing incidences of medical injuries. The P4P concept essentially envisions rewards for desired behaviors and outcomes. As we move forward with P4P implementation, it will be important to design these value-based purchasing programs in a way that specifically reward those health care organizations that transform themselves into "safe organizations" and that can demonstrate their adherence to safety principles.

Clinical guidelines are increasingly invoked in court to prove or disprove deviations from the standard of care. The pay-for-performance construct can also encourage appropriate adherence to clinical guidelines to improve quality and reduce liability risk. For example, financial incentives for practicing in accordance with guidelines can accelerate their adoption and use by clinicians who may otherwise be unaware of their content. This will lead to better care in general, but perhaps even more directly related to liability reform are studies that show that adherence to clinical guidelines can reduce legal risk. In one study that focused on obstetrical patients, there was a six fold increase in the risk of litigation for cases in which there was a deviation from relevant clinical guidelines.

Further, pay-for-performance programs at the federal level should be designed to encourage team approaches to care because teamwork has been identified by patient safety experts as an essential factor in reducing the risk of medical error. In aviation, predefined roles and responsibilities for varying scenarios are used to guide team development among pilots, flight attendants and other crew. Applying this approach consistently to health care delivery could increase the timeliness and accuracy of communications –breakdowns of which are commonly implicated sources of serious adverse events. Teamwork can also enlist clinicians and support staff in committing to a common goal –safe and effective care—in the often high pressured and chaotic environment of health care delivery. Pay-for-performance programs need to both reward

team performance and guard against any incentive-based program that is divisive to team approaches to care.

Another opportunity for action is to allow patient safety researcher's access to open liability claims to permit early identification of problematic trends in clinical care. One of health care's principal patient safety success stories is anesthesiology. The American Society of Anesthesiologists uses case analysis to identify liability risk areas, monitor trends in patient injury, and design strategies for prevention. In 2005, the ASA Closed Claims Project—created in 1985—contained 6,448 closed insurance claims. Analyses of these claims have revealed patterns in patient injury in the use of regional anesthesia, in the placement of central venous catheters, and in chronic pain management. Results of these analyses are published in the professional literature to aid practitioner learning and promote changes in practices that improve safety and reduce liability exposure.

Closed claims data analysis is the one way in which the current medical liability system helps to inform improvements in care delivery. However, reliance on closed claims for information related to error and injury is cumbersome at best. It may take years for an insurance or medical liability claim to close. These are years in which potentially vital information on substandard practices remains unknown. Providing patient safety researchers with access to open claims, now protected from external examination, could vastly improve efforts aimed at identifying worrisome patterns in care and designing appropriate safety interventions.

II. Pursuing Open Communication Between Patients and Practitioners

Our society has always valued open communication between patients and practitioners as a way to achieve high quality, safe care. But increasingly there is a "code of silence" when an unexpected and serious adverse event has occurred. An unintended consequence of the tort system is that it inspires suppression of the very information necessary to build safer systems of health care delivery. When it comes to acknowledging and reporting error, there is too often silence between practitioners and patients; practitioners and their peers; practitioners and the organizations in which they practice; and between health care organizations and oversight agencies.

In addition, the wall of silence is amplified by the fears of physicians and health care organizations about the loss of reputation, accreditation or licensure, and income. The wall of silence severely undermines efforts to create a culture of safety within health care organizations and across the health care system. The White Paper identified two areas in which legislation could be helpful. The first is to pursue legislation that protects disclosure and apology from being used as evidence against practitioners in litigation. Lack of disclosure and communication is the most prominent complaint of patients and their families, who together have become victims of medical error or negligence. Years of wounding and expensive litigation often ensue when families are sometimes only seeking answers.

For patients and their family members, the physical and emotional devastation of medical errors cannot be easily overcome. Research shows that what they want most out of their ordeal is honest and open dialogue about what went wrong, and a "legacy" that their experience serves as a lesson to prevent future occurrences of the same event. It has been demonstrated that when it occurs, they are much less likely to litigate a medical error. However, such communication and assurances are seldom forthcoming, although some prominent medical centers have adopted policies urging physicians to disclose their mistakes and apologies. Today, physicians and CEOs of health care organizations are afraid to make these apologies, expressions of sympathy, or commitments to change because they could be used in court as proof of negligence.

Among our report's recommendations for promoting transparency between patients and providers, we recommend that Congress consider ways to support and encourage state legislation that protects disclosure and apology from being used as evidence against

providers in litigation. More protections are needed in order for most caregivers and health care organizations to feel comfortable doing this despite the ethical imperative underlying such disclosure.

The second recommendation made in 2005 was for Congress to enact federal patient safety legislation that provides legal protection for information reported to a designated patient safety organization (PSO.) Again, we are very pleased that Congress passed this legislation last summer, and we are anxious for the Department of Health and Human Services to issue guidance for the establishment of PSOs. This legislation has the potential to unlock information we need to move more rapidly toward "systems-based" health care that protects inevitable human error from reaching the patient.

III. Creating an Injury Compensation System that is Patient-Centered and Serves the Common Good

In terms of restructuring the compensation system, there have been numerous proposals suggested over the past few years for making it both efficient and just for all parties by taking a proactive approach in administering the system. These proposals center on three broad approaches: 1) creation of alternative mechanisms for compensating injured patients, such as through early settlement offers often using schedules of compensation for frequent events; 2) resolving disputes through a so-called "no-fault" administrative system or using special health courts; and 3) shifting liability from a focus on individuals to a focus on organizations and systems. Though these approaches are distinct, they are not in conflict and could easily be combined.

Congress could assist in creating a patient-centered compensation system that is predictable and fair by conducting and funding demonstration projects through the Secretary of Health and Human Services of alternatives to the medical liability system that promote patient safety and transparency; that provide swift, equitable compensation to injured patients; and that encourage continued development of mediation and early-offer initiatives.

We need to test the feasibility and effectiveness of alternative injury compensation systems that are patient-centered and focused on safety. Such demonstration projects are needed to begin the process of mitigating the periodic medical liability crises that, aside from economic factors, result from the delivery of unsafe care, unreliable adjudication of claims, and unfair compensation for injured patients.

There are a large number of innovative suggestions geared to moving away from traditional tort litigation. Inherent to all of these ideas should be highly placed value on immediate acknowledgement of the error or injury; an apology; and assurances that steps will be taken to avoid such an error in the future.

Another potential action would be to redesign or replace the National Practitioner Data Bank (NPDB). Six years ago, the GAO recommended a significant overhaul of DHHS' data bank that collects information on adverse actions against clinicians in order to make it effective. No real change has occurred since that year 2000 report which found that the data were biased in favor of settlements and under-reported other information which was more reflective of practitioners' competence – such as disciplinary and hospital actions. Because of its operational, the NPDB represents a significant threat to physicians and is not useful for those who query in to better understand the competencies of clinicians who they want to hire. It also provides no insight into the actions that are reported, and disciplinary actions are vastly underreported. There is a need for a centralized data base that can capture important performance information about all licensed practitioners, but the NPDB needs significant overhaul to make it useful.

Conclusion

It is our contention that neither patients nor health care providers are well served by the current medical liability system. The central question is how the medical liability system can be restructured to actively encourage physicians and other health care professionals to participate in patient safety improvement activities. It is clearly time to actively explore and test alternatives to the medical liability system that stimulate the creation of "just cultures." This type of health care environments fosters learning—including learning from mistakes—and emphasizes individual accountability for misconduct.

Redesigning the medical liability system will necessarily be a long-term endeavor. This redesign will take a concerted effort by all stakeholders in which the legal and medical systems work together to solve these interrelated systems. Our mutual goal should be to reduce litigation by decreasing patient injury; by encouraging open communication and disclosure among patients and providers, and by assuring prompt, fair compensation when safety systems fail.

MR. DEAL. Thank you.

Mr. O'Connell.

MR. O'CONNELL. It shouldn't surprise me that a guy named O'Connell was a teenage friend of a guy named Pat Moynihan. I met Pat Moynihan through his younger brother, Mike. Anybody named Pat Monahan would obviously have a brother named "Mike." I mention Pat, because once he grew to your status as a legislator, he summed up the problem of being a legislator by saying, "You find out that this is a world of competing sorrows." Now does anything sound better than what you face each day, having to work with competing sorrows? Everybody is at you with their sorrow, whether it is from Detroit or take care of nine wives or whatever it should be.

In healthcare, there are a lot of competing sorrows. In malpractice, there are a lot of competing sorrows to address. But we have been very benefited today by having Dr. Mello here, because her report published recently in the New England Journal of Medicine is a brilliant one. It is so brilliant, I wish I had written it. But what she says, with her colleagues, pointing out, as many of you have indicated, these 5 and 6 years it takes to hear a claim, settle a claim, nevermind litigate it, and that more than half of the dollar goes to transaction costs. They end up saying substantial savings depend on reforms that improve the system's efficiency and the handling of reasonable claims for compensation.

Now that says it all. That is really a competing sorrow. And you and your staff should be very rigorous in questioning everybody who comes before you to talk about this problem as to what their proposals do to improve the system's efficiency in the handling of the reasonable claims for compensation.

This system that we have, for all its complexity, is based on true difficulties. In order to be paid, a patient has to claim that a healthcare provider was at fault, and that is very hard to determine. Claimants'

lawyers have to acknowledge that is very hard to determine or else how could they justify taking a third or more of compensation to help get it. Secondly, if the victim is paid after this 5 and 6 years of shin-kicking litigation, the victim is supposed to get paid for his non-economic loss, for his pain and suffering.

Well, now it is very hard to determine who is at fault, and I can tell you it is very hard to determine the dollar value of pain. You can't go to the Wall Street Journal today and find out what an aching elbow is worth. So almost anybody's opinion as to how much pain and suffering is as good as anybody else's, and how much that is worth in dollars is about worth as much in anyone's opinion as anyone else's.

Well, let me tell you what I am trying to do. I wouldn't come here and rage on like this unless I thought I had a solution. Let me tell you the solution that I am proposing that has been mentioned earlier. It is called early offers. It says this: any time a claim for malpractice is made, a defendant, or his insurer, has the option, not the obligation, of offering to pay within 180 days, a hell of a lot shorter than 5 and 6 years, the claimant's net economic loss, by which I mean the claimant's medical expenses and wage loss beyond any applicable insurance already there, such as claimant's own health insurance or Medicare or Medicaid or sick leave. If the defendant will make that offer, and he doesn't have to, but if the defendant will make that offer, the claimant has to accept it, unless the claimant can prove gross negligence and prove it beyond a reasonable doubt.

Now why do I do this? Because I want to take these two issues of fault and pain and suffering and, in a judicial movement, turn around and use those as leverage to get a compensation payment for the real losses that the acutely injured are suffering. I want you to keep in mind that the present system protects everybody but those who need it. Everybody. What do I mean? I mean the people who really need it are the people who have been seriously injured and don't have any health insurance to pay for their further health costs and no disability insurance to pay for their wage loss. They are in desperate circumstances. What does this system do? This system of justice? It hands them a lottery ticket. Even Dr. Mello says they have got a 25-percent chance of getting it wrong after 6 years of experts fighting about it. They give them a lottery ticket to say, "Well, maybe you will get paid years from now, and if you do, a lawyer will take a third or more of what you were paid." That is a hell of a way to treat seriously injured people. They are not protected by this system.

How about everybody else? Well, of course the doctors are protected. They get roughed up in this treatment, but they are protected by the fact that they have got liability coverage, right? The defense

lawyers are paid to win a lawsuit. The insurance companies are covered by the fact that they have got actual predictions as to what the exposure is. Plaintiffs' lawyers don't know how to take a guess unless they think they are going to win it. Even if they take a risky case, they have got a portfolio of cases for diversification. Seriously injured people don't have portfolio diversification. They have got one case. The less-than-seriously injured people are protected by the fact that they have been less seriously injured, and they are likely to have their coverages of healthcare and disability paying for their losses.

So this crazy system with all of this money, with all of this delay, with all of this frustration, is protecting everybody but those who need it the most.

So what does an early offer do? An early offer says to the defendant, "If you will take care of the people who really need help, you will be out of the litigation system unless you did something that is so bad it is a question of criminal law, and then you don't deserve any immunity from tort suit."

Let me just run a couple of examples by you. I am the patient. You are the doctor. You treat me. Something terrible goes wrong. We don't know why it happened, but I am in very bad shape. I am in such bad shape that if I got to you and won, I would get a million dollars in liability. But I have only got a one in two chance of winning. So I have got a $500,000 case, a one in two chance of winning, which is going to take me 4 or 5 years, or whatever Dr. Mello documents. It turns out, you could pay for my net economic loss by a corpus of $250,000. That would pay for my medical expenses and my wage loss, as they occur. So you would offer me my net economic loss, and I would have to take it. You would offer it because obviously $250,000 is a lot less than $500,000. I would have to take it, because I discovered in the study that I have done, a closed claim study, not as good as Mello's, but it is good, that 3 percent of the cases involve something like gross negligence. So I would have to take it. You would be better off, and I would be better off. The lawyers wouldn't be better off, but you and I would be.

Now change the facts slightly. I have still got the same injury. You are still a doctor. I have still got a million dollars of damages, but now I have a one in ten chance of winning. I have got a very marginal case. A very worthless case. I have suffered a million dollars worth of loss, but it is very unlikely that you were negligent. So now it is a case worth $100,000 because I have only got a one in ten chance of winning. You don't make the offer, and I don't deserve the offer. So I have guaranteed that nobody is going to have to make an offer unless they can save money. No plaintiff is going to lose his rights unless he is guaranteed his economic loss.

One could also build into this system that once the offer is accepted, the defendant healthcare providers have to sit down with the patient and explain just what will happen. So they will do this, not contention but on a willingness to sit down and describe what happened, because as you have earlier indicated, these are not people who are massacring people. These are mistakes, at best, and people want to know what happened.

MR. DEAL. Professor, I am going to ask you if you would conclude for us, please.

MR. O'CONNELL. I would conclude. Gladly.

So that is what the plan is. Let me tell you something, I have been doing this for about 40 years. If I had known how long it was going to take to get change, I would have undertaken the form of, I don't know, the Catholic Church.

Let me tell you, too. You have talked here a lot about the fact that you want to arrive at a solution. You know what I think? I don't think you will. I have heard legislators talk about this and not do anything, but I hope to hell you will prove me wrong.

Thank you.

[The prepared statement of Jeffrey O'Connell, J.D. follows:]

PREPARED STATEMENT OF JEFFERY O'CONNELL, J.D., SAMUEL H. MCCOY II PROFESSOR OF LAW, UNIVERSITY OF VIRGINIA

Summary

In the May 11, 2006 issue of the New England Journal of Medicine authors David Studdert and Michelle Mello and their colleagues reported on a closed claims study of medical malpractice claims. The study found that the system takes far too long - on average five years from the occurrence. The study also found that it chews up far too much in overhead costs, principally legal fees on both sides, amounting to more than half (54%) of any compensation paid. In the words of the study, "substantial savings depend on reforms that improve the system's efficiency in the handling of reasonable claims for compensation."

It is just such a change that my testimony proposes:

Under the early offer bill, liability insurers for health care providers have the option within 180 days after a claim is filed of making an offer, binding on claimants, to effect periodic payment equal of claimant's net economic loss (i.e., beyond any other insurance), plus reasonable legal fees, but nothing for pain and suffering. If the claimant does not accept this offer, the claimant can proceed with a normal tort claim for both economic and noneconomic damages, but the legal standards of both the burden of proof and level of misconduct applied to the claim would be raised, with the claimant having to prove the defendant grossly negligent beyond a reasonable doubt. If the defense does not make an offer, the current system applies.

Testimony

Insurers would decide whether to make the early offer described in the Summary above by comparing the cost of the early offer to their expected cost under normal tort rules assuming the claim is not settled under the early offer proposal. This expected cost would equal the net economic damages (medical expense and wage loss but, as stated,

not pain and suffering) plus an allowable payment of the claimant's lawyers, which is presumed to be 10 percent of the value of the early offer. That is, the insurer will make an offer when the expected liability and litigation costs if the claim is not settled under the early offer proposal are greater than the net economic damages and the allowable claimant's legal fees.

Thus, the insurer will make an early offer when the amount of the early offer is less than the insurer's expected exposure from a full-scale tort claim.

Numbered items i and ii below present some of the main criticisms of current medical malpractice law.[1] Numbered items iii-xi below relate the early offer proposal to the medical malpractice reform debate.

i. Many observers view the current system of tort liability for personal injury as unworkable and in need of fundamental reform. Under the current system, a claimant must prove two difficult elements: the defendant's fault, and the financial value of noneconomic damages, mostly for pain and suffering. In medical malpractice cases, determining fault is often especially complex, given the intricacies of medical decision contexts and the probabilistic consequences of medical interventions and their interaction with underlying patient characteristics. As a result, the system is subject to uncertainties that allow many injured patients to receive little or nothing while comparably injured others are paid much more than their economic losses. One earlier finding indicated that only 28 cents of the medical malpractice premium reaches claimants, and of that, only 12.5 cents goes to compensate for the actual expenses incurred by patients, with the rest going to legal fees, insurance overhead, and the like.[2] As pointed out, all this uncertainty generates not only substantial transaction costs (mostly legal fees on both sides) but long delays in any payment that is made, usually measured in years. In the end, the liability insurance system does not result in prompt payment to many needy victims; rather, it is a system of prolonged, unpredictable, expensive fights over whether claimants are deserving and/or what payment they deserve -- a system that often operates to the detriment of both health care professionals and injured patients, especially seriously injured patients.

ii. The present system of tort liability insurance for medical injuries may lead to the anomalous result of providing the least protection to those who need it most: seriously injured parties whose medical expenses and wage losses exceed any applicable private or public insurance coverage. The present legal system in effect tells patients that they may be paid something, but only years from now and only after paying out or any recovery lawyer's fees of 30 percent or higher.

The tort system imposes far fewer risks on the various medical malpractice liability participants who are not seriously injured victims. Health care providers typically have protection through their liability insurance coverage, and their insurers are protected by their risk-spreading, strengthened by actuarial calculations. Defense lawyers are paid, win or lose. Claimants' lawyers have little incentive to take a case unless they are confident it is likely to lead to an expected payment in excess of their expenses and opportunity costs. Even if the risk of nonpayment for any given claim is high, the claimants' lawyer can

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[1] The following numbered items i-ix are adapted from Jeffrey O'Connell, *Statutory Authorization of Nonpayment of Non-economic Damages*, 71 Tenn. L. Rev. 191-95 (2003). For a brief presentation of the inadequacies of current medical malpractice law, see Jeffrey O=Connell & Andrew S. Boutros, *Treating Medical Malpractice Claims Under A Variant of the Business Judgment Rule*, 77 Notr. D. L. Rev. 373, 374-83 (2002). Two recent works, while purporting to rebut criticisms of medical malpractice law, nonetheless acknowledge its inadequacies in proposing substantial reforms, in the first instance even proposing a variant of early offers to reduce exposure to pain and suffering damages. See David A. Hyman and Charles Silver, *The Poor State of Heath Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?* 90 CORNELL L. REV. 893, 986-87, 992 (2005); TOM BAKER, THE MEDICAL MALPRACTICE MYTH 90, 163-64; 172-74 (2005).

[2] Jeffrey O'Connell, *An Alternative to Abandoning Tort Liability* 60 MINN. L. R. 501 506-09 (1976).

minimize this risk by taking multiple cases to assure portfolio diversification, a form of protection denied to the seriously injured victim, who normally will have only one such claim in a lifetime. Finally, the less seriously injured are relatively protected by the very fact of their lesser losses which may, in turn, be covered by their own health insurance or sick leave.

iii. The early offer reform addresses the main shortcomings of the current system. Before considering the benefits of early offers, it is useful to review their structure. Under such an approach, a defendant has the option (not the obligation) to offer an injured patient, within 180 days after a claim is filed, periodic payment of the claimant's net economic losses as they accrue. Economic losses under an early offer statute must cover medical expenses, including rehabilitation plus lost wages, to the extent that all such costs are not already covered by other insurance ("collateral sources"), plus an additional 10 percent attorney's fee. Therefore, a defendant cannot make a lesser or "low ball" offer and still be covered by the statute. Nor is there any need for a court to determine whether the early offer is fair. The early offer statute defines the fairness of the offer, similar to a workers' compensation statute for workplace accidents.

If an early offer is made and accepted, that, of course, settles the claim. If the defendant decides not to make an early offer, the injured patient can proceed with a normal tort claim for medical expense and wage loss plus pain and suffering. Alternatively, if the claimant declines an early offer in favor of litigation, (1) the standard of proof of misconduct is raised, allowing payment only where "gross negligence" is proven; and (2) the standard of proof is also raised, requiring proof of such misconduct beyond a reasonable doubt (or at least by clear and convincing evidence).

iv. Consider a typical case to illustrate how the early offer law would work. A patient has been injured in the course of treatment. If the patient wins in court, she would be awarded $1 million, but given the risks of litigation, she has only a 50 percent chance of winning. Roughly calculated, the patient has a claim worth about $500,000 (50 percent chance at $1 million). Assume the cost of setting aside a corpus of money to pay the patient's net economic losses as they accrue is projected at about $250,000 (an often realistic assumption in such a case, as studies demonstrate). The health care provider's insurer would likely make the early offer, $250,000 being clearly less than $500,000. And the patient would likely accept, given that under the early offer proposal the plaintiff will have the normally insuperable burden of proving her doctor guilty of gross negligence beyond a reasonable doubt.

Now assume a change in the facts: same patient, same health care provider, and the same possible $1 million verdict. But here assume this patient's chances of winning are only one in ten, with an expected value of $100,000 (1/10 of $1 million). Here the defendant's insurer would not make an early offer, $100,000 being clearly less than $250,000.

v. The fear of potentially higher costs to insurers under this early offer scheme is avoided because no defendants need make an offer if they would not do so without this statute. Thus, defendants will make an offer only when it makes economic sense for them to do so, as shown in the example above.

vi. But won't insurance companies thereby just "cherry pick" claims by making lower payments to clearly deserving claimants? Because of the uncertainty and cost of determining both liability and pain and suffering damages under present tort law, it is likely, as indicated in Item iv above and the report itself below, that defendants in medical malpractice cases will make prompt early offers in many cases even when liability is unclear.

vii. The proposal would affect injury victims in many ways that are advantageous. While injury victims would lose their recourse to full-scale tort litigation, they would reduce their uncertainty, delays, and transaction costs. Moreover, they would lose their current tort litigation recourse only when they are guaranteed prompt payment of their

actual economic losses plus attorney's fees. These prompt and certain payments will be especially advantageous to those seriously injured patients whose losses have outstripped other applicable coverage.

viii. Several factors make it unattractive for early offers to be made voluntarily without an early offer statute. Defendants today may be confident of defeating or at least wearing down claimants, given the difficulties and delays in proving a tort claim. The long delay before trial may often enable defendants to bargain down even claimants clearly entitled to tort damages because the latter may need immediate money for accrued and accruing medical bills and wage loss. Furthermore, defendants may fear that an early offer to settle for claimants' net economic loss will be seen as a signal of weakness and encourage claimants and their lawyers to seek an even larger settlement than originally sought. This mirrors the position of claimants and their lawyers, who similarly fear that an early offer to settle only for economic loss would be deemed an admission of weakness in their cases, resulting in either no payment or less than that otherwise sought.

ix. Early offers will be a viable mechanism only if defendants, not claimants, are allowed to make binding early offers. Claimants and their counsel would lack sufficient incentives to weed out frivolous or non-meritorious claims if they had the power to unilaterally bind defendants by their claims. This would result in a perverse incentive to exploit the system with marginal claims or worse which would nonetheless be binding on defendants. But defendants, as the parties making payment, when confronted with clearly meritless or very marginal claims will pay nothing and make no early offer, as shown in the example above. On the other hand, when faced with potentially meritorious claims, defendants will have an incentive to explore whether the statutorily-defined early offer involves less expected cost than a full-scale tort suit with all its uncertainty and transaction costs. Thus, only defendants have the appropriate incentives to distinguish carefully between arguably meritorious and clearly non-meritorious claims in order to reduce costs by promptly paying the required minimum benefits in suitable cases.

x. There are also several rationales for why damages for pain and suffering are not included in the early offer reform. The uncertainty of determining both liability and damages for noneconomic damages is the key to understanding the inefficiencies of tort law and to framing a balanced solution that attempts to be fair to both injured patients and health care providers. Pain and suffering damages are indeterminate and highly volatile. Under an early offer system, the prospect of an award of pain and suffering damages nonetheless still serves as a means of internalizing health care providers' medical mishaps by providing an incentive to make early offers covering injured patients essential economic losses. These offers thus will provide prompt compensation to many victims of injuries that accompany the delivery of medical services. In effect, the threat of paying damages for pain and suffering, rather than the actual payments, will better serve injured patients as well as the public interest.

Pain and suffering damages also differ from economic damages from the standpoint of insurance.[3] Because accidents and illnesses generally reduce the marginal utility of income, people do not generally find it desirable to purchase pain and suffering insurance. Indeed, no such general insurance market has emerged. In contrast, risk-averse individuals will desire full insurance of their economic losses, which is the focal point of the early offer proposal.

Because personal injury claims alone among all other damage claims routinely entail damages for both economic and noneconomic losses, defendants are uniquely positioned not only to make, but also to enforce by early offers, socially attractive settlements for only economic loss. In non-personal injury claims, where only economic damages are at

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[3] See W. Kip Viscusi, *Pain and Suffering: Damages in Search of a Sounder Rationale*, I MICHIGAN LAW AND POLICY REV 141 (1996).

stake, no comparably fair means are available to sanction a claimant who refuses to accept an offer of only a portion of the total losses claimed.

xi. A complete no-fault plan for medical injuries does not seem feasible. It is difficult to define in advance when no-fault benefits should be paid for injuries that arise from medical treatment. Under no-fault auto insurance policies, an accident victim is compensated for an injury "arising out of the ownership, maintenance, or use of a motor vehicle." Under workers' compensation laws, an industrial accident victim is compensated for an "injury arising out of, and in the course of, employment." It is not feasible, however, to force all health care providers to pay patients for any and all adverse events arising in the course of medical treatment. It is often impossible to determine whether a patient was injured by the treatment rendered, or whether the adverse condition after treatment was just a normal extension of the condition which prompted treatment in the first place. A health care provider could not be expected to pay every patient whose condition worsens after treatment. Thus such a comprehensive *ex ante* no-fault solution is unworkable, and therefore unavailable. The proposed early offer system for medical accidental injuries enables, when the facts are much better known, *ex post* comparisons of the cost of a tort claim versus that of an early offer, and so this system seems a uniquely workable, economical, equitable, and simplifying solution.

Some operational features of the early offer plan

It may be useful, for example, to address some questions regarding the time frame for operation of the early offer plan. Is the 180-day period too short a time for the defendant to decide to make an early offer? In general, insurers already compute their initial reserve amounts in a much shorter period, and the preliminary discovery process would be accelerated by the early offer structure. In addition to doing research to decide whether to bring a claim, claimants and their lawyers can also take their time and press any discovery they deem necessary before responding to any early offer.

Court approval of the terms of an accepted early offer will no more be required than is court approval of the terms of a workers' compensation case. Of course, there may be later disputes after an early offer settlement regarding what is due periodically as losses accrue in the future, but that can happen under workers**=** compensation or any major medical/disability policy extending into the future. Courts now routinely review settlements in minors' cases, a practice that presumably will continue.

An early offer settlement is no worse than lump sum court awards in dealing with seemingly difficult questions, such as whether the claimant's condition might change. The parties also might agree to a structured settlement,. *i.e.,* present estimates which would bypass the need for future recalculations of amounts as they are due. In the case of death, the survivors would be due the amount, if any, that the decedent's earnings would have been expected to provide as support. Note that the Michigan no-fault auto law with its large wage loss coverage extending to the hundreds of thousands of dollars has been able to deal effectively with such matters.

As to the limit on claimant attorneys' fees to 10 percent of the value of the early offer, this percentage is based on a comparison of (1) the current almost uniform minimum of one-third of the value of a full-scale tort settlement or verdict and (2) the claimant's attorney fees under no-fault workers' compensation, which are not uncommonly limited to 10 percent for losses above a minimum payment.

Note further that by definition there will be no trial expenses under early settlements. Note too that the early settlement will also greatly diminish pre-trial expenses. Also, if the 10 percent fee is manifestly too low because of special circumstances, claimant's counsel can petition the court for an augmentation that will be payable by the early offerer.

When an early offer makes sense, all the insurers involved in the case, should join together in making the early offer. If not, insurers not making an early offer would be

left with a claimant no pursuing economic damages with no offset for collateral sources, plus non-economic damages. Indeed such a case would be financed by payment from any other insurer's early offer. As a practical matter disputes over division of the ultimate cost to any given insurer would be handled later through arbitration.

Conclusion

An economic model of the cost and other effects of the early offer proposal shows a typical result as follows: With the parties stalemated after years of negotiation between $279,000 and $408,000, an early offer of $190,740 covering claimant's net economic loss, plus 10% for claimant's attorney's fee, would have netted claimant $173,400 and settled the case promptly.

The model especially highlights the "wedge" effect, that current law induces in placing barriers between claimants and defendants, greatly inhibiting efficient settlements B a wedge that early offers greatly diminish.

> A Wedge Effect . . . exists when buyers and sellers in a market must share a cost related to consummating a transaction. The Wedge is the amount by which the purchase price to the buyer is raised plus the amount the selling price received by the seller is reduced. The paradigmatic example is the sales tax on goods. To the extent that litigation-based costs cause a Wedge Effect in the market for resolution of medical malpractice claims, the current [tort] system artificially prevents some welfare-enhancing settlements, reduces the compensation of claimants unnecessarily, inflates the payment of defendants and creates a deadweight loss.[4]

The early offer reform should lead to cost savings and speedy resolution of many cases if adopted. The main benefit to claimants of the early offer reform is that if an offer is made and accepted, claimants receive assurance of payment that covers their net economic losses approximately six months after the claim is filed. Payment will thus be received much sooner than under the current system and with much lower transaction costs.

The disadvantage to the claimant of accepting the early offer is that the possibility of receiving noneconomic damages is eliminated. Since noneconomic damages often involve greater sums than economic damages, this loss is admittedly significant. But only in about 3 percent of present cases does the possibility of punitive plus noneconomic damages exist. Under an early offer regime even in such cases victory would not be assured since the burden of proof would be substantially greater than it is now.

Although, the extent to which savings from early offers would be passed on through lower malpractice insurance premiums is unknown, assuming a competitive marketplace, one certainly can expect that to happen.

MR. DEAL. Thank you.

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[4] Jeffrey O'Connell, Jeremy Kidd, & Evan Stevenson, An Economic Model Costing AEarly Offers@ Medical Malpractice Reform, 35 N. Mex. L. Rev. 259, 280.

Ms. Doroshow.

MS. DOROSHOW. Thank you, Mr. Chairman, members of the subcommittee.

I want to address my remarks mostly on the issue of health courts, because a lot of the testimony refers to those. I do want to, though, before I begin, just review for a moment what the study that has been referred to that Dr. Mello participated in and what the New England Journal of Medicine did find. That study, and I think if you read it, actually for the purpose of this hearing, in terms of the way the system really is working. That study found that most of the claims that result from errors, those individuals receive compensation. On the other hand, most individuals whose claims did not involve errors or injuries receive nothing. Eighty percent of claims involved injuries that cause significant or major disability or death. Disputing in paying for errors account for the largest share of malpractice costs for errors. Fifteen percent of the cases are going to trial. That means a large majority of them are settling or there are some other kind of alternative compensation systems or processes currently taking care of the majority of these claims.

In this very same issue in the New England Journal of Medicine, there was a companion piece which discussed how litigation against hospitals is critical for ensuring patients' safety. So there is a patient safety issue involved here that would be very detrimentally affected by removing litigation as a prospect, at least in the case of hospitals.

Now the Center for Justice & Democracy, that I am the Executive Director of, works with a number of malpractice victims, and none of them have been very active in their fight against caps on damages. But a couple of weeks ago, we have reached out to them on the issue of health courts, because there was a hearing on the Senate side on this issue. I cannot tell you how surprised I was to see the immediate and intense response from the victims that we worked with who were horrified by the prospect of health courts. I can't tell you how distressed they were. These individuals that, for the most part, never went to trial, their cases were resolved by mostly pre-settlement negotiations, a form of alternative dispute resolution which currently exists in the system, which is voluntary and does not remove the individuals' fundamental right to jury trial. They strongly object to requiring that cases be forced into an informal administrative system without any prospect of a jury or an unbiased judge hearing their case or ensuring the fairness of the proceeding and also a one-size-fits-all schedule for compensation for these victims. They feel very strongly this would deny justice to them and to those who would be injured in the future.

Going into more detail about the specific health court model, I feel there are areas that are particularly of concern to us and to the victims we

work with. The specialized judge that would be ruling in these cases would certainly not be unbiased. They have been described as mutual, but they would be coming from the healthcare industry, the medical industry in some way. The experts that they would hire to advise them would, as well, play a very large role in these health courts. Liability is basically a form of negligence. This avoidability standard is a form of negligence, so you are basically forcing the patient into an administrative system, having to prove virtually the same thing in terms of liability, but without the procedural protections that a court provides without an unbiased judge to ensure fairness.

The compensation schedules, the victims are obviously very concerned about this, not only because they don't take into account the individual circumstances of someone's life, but because once, and this is the lesson of all administrative systems when you set them up by statute and compensation is set up in a schedule in a statute, they become vulnerable to political influences. If you look at the workers' compensation system, it started out with very good intentions in the early part of this century to help workers. You will see the steady chipping away of compensation and benefit levels to workers, even to the point where some systems now have been completely gutted for workers because of the costs, because the insurance companies will go in there every year to State legislatures and get the benefits chipped away. In Florida, in virtually every session since that workers' comp statute was set up in 1935, those benefits have been chipped away.

Taking away a jury in this situation, the vague promises of efficiency and so forth that have been promised, in no way equal the magnitude of what is being proposed here to being taken away from victims, the right to a jury trial. There are also very serious constitutional concerns about that, which I don't believe are surmountable. But if you look at the claims of efficiency and speed, they are derived by almost every administrative compensation system that has ever been instituted in this country, all of which are plagued by bureaucratic problems, political capture problems.

Just very briefly, the experts that have been contemplated here, in all of the models that we have seen, although very skeletal at this point, these experts coming from the industry would play a very large role in determining compensation and determining fault. This is very unfair to victims. Victims need to have lawyers helping them in these situations, and the lawyers need to have experts. They have a right to have that, and they have a right to have the experts go up against the insurance companies' experts, and that is what you need a jury to determine. Juries, their quintessential function is to determine fault in those kinds of

situations and the fairness of what a victim is going to need, particularly, when you are talking about future medical expenses.

Just to conclude, we do not object, and the victims that we work with absolutely do not object, to alternative compensation systems, provided they are voluntary, provided that they do not eradicate the fundamental right that we have in this country to jury trial. Most of the victims we work with take advantage already of those systems already in effect. If you are going to look at trying to improve the efficiency of some of those systems, we would be all for it, but they must be voluntary, and they must ensure the right to jury trial.

Thank you.

[The prepared statement of Joanne Doroshow follows:]

PREPARED STATEMENT OF JOANNE DOROSHOW, EXECUTIVE DIRECTOR, CENTER FOR JUSTICE & DEMOCRACY

Mr. Chairman, members of the Committee, I am Joanne Doroshow, President and Executive Director of the Center for Justice & Democracy, a national public interest organization that is dedicated to educating the public about the importance of the civil justice system.

In addition to our normal work, CJ&D has two projects: Americans for Insurance Reform, a coalition of over 100 public interest groups from around the country that seeks better regulation of the insurance industry; and the Civil Justice Resource Group, a group of 24 prominent scholars from 14 states formed to respond to the widespread disinformation campaign by critics of the civil justice system.

I appreciate the opportunity to address the issue of medical malpractice litigation and patient safety. Today, I would like to discuss why mandatory alternatives to medical malpractice litigation would not only have terrible consequences for patients, but also hurt patient safety.

INTRODUCTION AND SUMMARY

CJ&D and the malpractice victims with whom we work all agree that alternative systems, where both parties voluntarily agree to take a case out of the civil justice system, are not only appropriate, but currently resolve the vast majority of legitimate medical malpractice claims today. Most victims with whom we work resolved their cases through informal pre-trial settlements. This is consistent with findings published in the May 11, 2006 *New England Journal of Medicine,* that only 15 percent of claims are resolved by jury verdict today.[1]

There is nothing wrong with alternative dispute resolution (ADR) or alternative compensation systems, provided they are truly voluntary and do not eliminate the right to trial by jury. This view is consistent with a July 27, 1998 report released jointly by the American Medical Association, the American Bar Association and the American Arbitration Association, entitled *Health Care Due Process Protocol*, which found that, "[t]he agreement to use ADR should be knowing and voluntary. Consent to use an ADR process should not be a requirement for receiving emergency care or treatment. In disputes involving patients, binding forms of dispute resolution should be used only where the parties agree to do so after a dispute arises."

[1] David M. Studdert, Michelle Mello, et al. "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine,* May 11, 2006.

However, we and the medical malpractice victims with whom we work strongly object to schemes that *require* that cases be heard in informal settings, such as Health Courts, without the option of having either juries or unbiased judges making decisions, and with schedules of benefits that deny individual justice. Such systems tilt the legal playing field heavily in favor of insurance companies that represent health care providers. This is especially so in systems where the burden of proof on patients (as is contemplated by so-called Health Courts) is little different than would be required in a court of law.

What's more, removing the possibility of jury trial will infect the bilateral bargaining/settlement process, through which most legitimate medical malpractice disputes are resolved. Ordinarily, the victim's warning that he or she is prepared to take a case before a jury helps to ensure a fairer settlement. Without the prospect of a jury trial, the health care/insurance company's leverage in any settlement negotiation is greatly increased, to the detriment of innocent patients.

Moreover, it is bad enough that the law contemplates a one-size-fits-all schedule of benefits that, like caps, take into account no individual circumstances of a person's life. But also, political bodies will set these compensation judgments, and insurance and health industry representatives can lobby these bodies. It is the lesson of history that, unlike our courts and juries, political money and lobbying can easily influence legislatures and agencies that retain the sole power to redefine limits and benefits under codified compensation systems. Once political forces take over a statutory system, as they always do, it is merely a matter of time before even the most pro-victim proposal is turned into a nightmare for the injured person.

Removing the threat of litigation would also disrupt other critical functions of the legal system, most importantly the deterrence of unsafe practices, especially in hospitals as explained below. Clearly, we need to look for ways to improve the quality of health care services in our country and to reduce preventable medical errors. Alternatives to litigation will not only fail to fully compensate patients, but they will also undermine restraints the civil justice system currently imposes on dangerous conduct.

Patient safety should be our first priority. There are many productive areas to focus upon – weeding out the small number of doctors responsible for most malpractice, improving nurse staffing ratios, to mention just two. Mechanisms that shield grossly negligent doctors from accountability by intruding upon the legal system are simply the wrong way to go.

WHERE'S THE CRISIS?

On May 11, 2006, two articles published in the *New England Journal of Medicine* lead to the conclusion that despite a tremendous amount of negative rhetoric about medical malpractice litigation, the medical malpractice system works pretty well.

In their closed claims study, Michelle Mello, David M. Studdert and others found that despite its costs, the current system works: legitimate claims are being paid, non-legitimate claims are generally *not* being paid, and that "portraits of a malpractice system that is stricken with frivolous litigation are overblown."[2] The authors found:

- Sixty-three percent of the injuries were judged to be the result of error and most of those claims received compensation; on the other hand, most individuals whose claims did not involve errors or injuries received nothing.
- Eighty percent of claims involved injuries that caused significant or major disability or death.
- "The profile of non-error claims we observed does not square with the notion of opportunistic trial lawyers pursuing questionable lawsuits in circumstances in which their chances of winning are reasonable and prospective returns in the event of a win are high. Rather, our findings underscore how difficult it may

[2] *Ibid.*

be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information that litigation triggers."

- **"**Disputing and paying for errors account for the lion's share of malpractice costs."
- **"**Previous research has established that the great majority of patients who sustain a medical injury as a result of negligence do not sue. … [F]ailure to pay claims involving error adds to a larger phenomenon of underpayment generated by the vast number of negligent injuries that never surface as claims."
- Patients "rarely won damages at trial, prevailing in only 21 percent of verdicts as compared with 61 percent of claims resolved out of court."

The authors also determined that the costs of the current system were high – but compared to what? Medical malpractice cases represent a tiny fraction of cases that pass through the civil courts every day. Health Courts contemplate establishing an entirely new administrative bureaucracy to accomplish the same thing. Insurers will still fight claims. Independent witnesses for both sides will still be needed. The Health Court process would hardly save money - unless it was done on the backs of injured patients who would be less likely to obtain adequate compensation under this system.

The second article from the May 11, 2006, *New England Journal of Medicine* argued that litigation against hospitals improves the quality of care for patients.[3] The article also confirmed that removing the threat of litigation would do nothing to improve the reporting of errors since fear of litigation is not the main reason doctors do not report errors. Highlights of this article include:

- "In the absence of a comprehensive social insurance system, the patient's right to safety can be enforced only by a legal claim against the hospital. … [M]ore liability suits against hospitals may be necessary to motivate hospital boards to take patient safety more seriously."
- "The major safety-related reasons for which hospitals have been successfully sued are inadequate nursing staff and inadequate facilities." For example, the Illinois Supreme Court found that a hospital was at fault for failing to provide enough qualified nurses "to monitor a patient, whose leg had to be amputated because his cast had been put on too tight."
- Anesthesiologists were motivated by litigation to improve patient safety. As a result, twenty-five years ago, this profession implemented "a program to make anesthesia safer for patients" and as a result, "the risk of death from anesthesia dropped from 1 in 5000 to about 1 in 250,000."
- Only one quarter of doctors disclosed errors to their patients, but "the result was not that much different in New Zealand, a country that has had no-fault malpractice insurance" [i.e., no litigation against doctors] for decades. In other words, "There are many reasons why physicians do not report errors, including a general reluctance to communicate with patients and a fear of disciplinary action or a loss of position or privileges."
- "[B]y working with patients (and their lawyers) to establish a patient's right to safety, and by proposing and supporting patient-safety initiatives, physicians can help pressure hospitals to change their operating systems to provide a safer environment for the benefit of all patients."

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[3] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.

Finally, statistics suggest that few who are injured by medical negligence actually file a claim, go to court, or receive any compensation for their injuries.[4] Proponents of Health Courts call this a litigation crisis that can be resolved with alternative systems. This is absurd.

First, patients who are injured by medical malpractice usually do not know that negligence was involved in the first place, or even suspect it. Hospital records certainly do not indicate errors. This situation would be no different if patients were forced to litigate in Health Courts. Certainly, the hardball litigation tactics of insurance companies that deny and fight legitimate claims will not suddenly stop either. Second, sometimes it is only after an attorney agrees to take a case, goes through the laborious process of obtaining hospital records, and has their own experts evaluate the information, that negligence can be proven. This process would be no different with Health Courts, but would be even more difficult for the patients because there would be no judge or jury to ensure a fair process. In fact, bias in the process may make it less likely that an attorney will financially risk taking the case at all.

Finally, there are many reasons why malpractice victims do not sue even when they know negligence was involved. My own father's cancer was misdiagnosed by his family physician. No one in my family even considered the notion of suing this doctor, and would not have done so no matter what kind of process was available to us. These kinds of stories are repeated every day in this country. But when a child is catastrophically injured or the breadwinner of a young family is rendered quadriplegic, families need and deserve the kind of compensation that a judge or jury, who listen to the evidence in each individual case, decide is best. While presented ostensibly for the benefit of victims, Health Court proposals show nothing but misguided concern for what is best for patients and, particularly, the most severely injured patients.

MODELS

Sorry Works

Several alternative compensation proposals for medical malpractice cases have been discussed over the last year. The Medical Error Disclosure and Compensation (MEDiC) Program, also known as "Sorry Works", is problematic. Under the current federal proposal, "health care providers would report patient injuries to a designated officer who would determine whether those injuries resulted from a medical error. In the event that a medical error occurred, providers would explain the incident to patients, offer an apology and enter into compensation negotiations. The apologies would remain confidential, and patients could not use them as an admission of guilt in legal proceedings."[5]

There are several concerns. First, the civil justice system is structured to neutralize resource and power imbalances between the parties. Without it, negotiations become heavily tilted in favor of the doctor or hospital. There is little doubt that an uninformed patient, particularly one who is catastrophically injured, will be pressured by insurers to resolve their case for a fraction of what they need or deserve, particularly when it comes to future medical expenses. Because there is no requirement that the patient be represented by counsel, these negotiations will be extremely perilous for the injured patient. If the dispute goes to mediation, this can also be dangerous for the injured patient. Mediation can make a dispute appear as a conflict between equals that should be worked out on amicable terms for both, inducing the feeling on the injured victim's part that he or she should compromise, regardless of the justice of his or her claim.

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[4] Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York,* 1990.

[5] "Medical Errors: Rodham Clinton, Obama Propose Disclosure; Program, *American Health Line*," September 29, 2005.

Another problems is that, while there is the right to proceed to the judicial system if no agreement is reached after six months, the bill does not toll the statute of limitations during the negotiation period, which is a serious problem in states that have only a 1 year statute of limitations. Finally, it hardly needs to be said that keeping an admission of wrongdoing out of court is not only unfair to patients who have been hurt, but increases transaction costs as patients are forced to build their case from scratch. The real problem is the insurance company that fights patients in these cases, rather than acknowledge the culpability of the health care provider that they insure.

Health Courts

The Health Court model has generated a good deal of interest and is being strongly pushed by Common Good. The proposal that is taking shape has the following key features: specialized judges with an expertise in health care; experts hired by the Health Court; a modified form of negligence (termed "avoidability"); a compensation schedule; no juries; and no access to civil court review.

As for the standard of liability, the Health Court proposal being discussed most recently relies on a new standard entitled "avoidability." This is not a "no-fault" standard but rather contemplates some element of fault, or a judgment that care was somehow sub-optimal and this lower level of care resulted in injury.

Avoidability appears to draw from a standard applied in Sweden and lies somewhere between negligence and strict liability. It should be noted that Sweden, which is often cited as the model for current Health Court proposals, allows for tort remedies to co-exist alongside Health Courts. Moreover, Sweden has an array of other public benefits that offset costs of injuries regardless of any claims. In the U.S., however, where there are very few public benefits, the proponents of Health Courts are adamant about the exclusivity of Health Courts and the removal of all access to the court system. This can only result in injured people having to shoulder much more of the cost of the injury, without any accountability mechanisms being placed on the health care industry.

REMOVING THE JURY

Proponents of Health Courts waive away constitutional problems raised by eliminating the right to trial by the jury by citing to worker's compensation, vaccine injury compensation, tax courts, and even the National Labor Relations Board. Although each of these programs was built on a different authorizing structure, they all share an adjudication function without the aid of juries. They are also all distinguishable from Health Courts. The compensation schemes are all based on no-fault models, and the remaining alternative schemes adjudicate public, federally-created rights, not private long-standing state common law rights.

In fact, almost every state constitution guarantees the right to trial by jury in civil cases and the right to access the court system for redress. Health Courts require that patients give up these rights without any reasonable substitute. A majority of states will likely find health "courts" unconstitutional based on their state constitutional provisions safeguarding the right to a jury, the right to open access to the courts and/or the right to due process.[6]

Moreover, the determination of fault under common law is the quintessential jury function, and empirical studies support the view that a jury's ability to handle complex litigation, including medical malpractice cases, is not a problem, and has never been a

[6] See, Amy Widman, Center for Justice & Democracy, "Why Health Courts are Unconstitutional" (publication forthcoming by the Pace Law Review), http://centerjd.org/press/opinions/HealthCourtsUnconstitutional.pdf.

problem."[7] Juries, through the group processes of collaboration and deliberation, are particularly well-suited for complex cases.[8] Jury verdicts are consistent with those of other decision-makers. A doctor-led research group examined 8,231 closed malpractice cases in New Jersey and found that the verdicts rendered by juries in the few cases that went to trial correlated with the judgment of the insurers' reviewing physicians."[9] Another analysis of various studies found: "Researchers have repeatedly found that juries and judges reach extremely similar conclusions about tort liability."[10] "Other researchers found that the evidence on judge-jury concordance in complex cases is very favorable. In one study of malpractice trials, for example, juries were harder on plaintiffs than judges were."[11]

Moreover, judges, who see how juries function every day, have enormous confidence in the jury system, including their ability to handle complex cases. In March 2000, the *Dallas Morning News* and Southern Methodist School of Law sent questionnaires to every federal trial judge in the United States, its territories and protectorates – over 900 judges. About 65 percent (594) of the federal judges responded.[12] The paper reported, "The judges' responses reflect a high level of day-to-day confidence in the jury system. Only 1 percent of the judges who responded gave the jury system low marks…. Ninety-one percent believe the system is in good condition needing, at best, only minor work… Overwhelmingly…judges said they have great faith in juries to solve complicated issues…. Ninety-six percent said they agree with jury verdicts most or all of the time. And nine of 10 judges responding said jurors show considerable understanding of legal and evidentiary issues involved in the cases they hear."[13]

STACKING THE PROCESS AGAINST THE PATIENT

Proponents of alternatives like Health Courts often make vague promises that an alternative system will be fairer to plaintiffs and/or will provide more compensation accompany such proposals. They point to benefits such as "free legal representation," "efficiency," and "quicker resolution," as reasonably just substitutes for a plaintiff's right to open access of the courts and right to trial by jury.[14]

At the outset, it is worth noting that there is no free legal representation being offered as part of the Health Courts model or any of the alternative systems. An attorney is not mandatory, but neither is this true for our civil justice system. But clearly, victims feel that they fare better with an attorney representing them and it is safe to assume the same will be true for the Health Courts, if not even more so as the administrative tribunal will have less procedural safeguards in place to assure fairness. Although it is true that a plaintiff may be given access to free "experts," these are experts picked by a panel heavily weighted toward industry.

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[7] Philip G. Peters, Jr. "The Role of the Jury in Modern Malpractice Law," 87 *Iowa L. Rev.* 909, 927-28 (2002), http://papers.ssrn.com/sol3/Papers.cfm?abstract_id=310681.

[8] *Ibid.*

[9] Marc Galanter, "Real World Torts: An Antidote to Anecdote," 55 *Maryland L. Rev.* 1093, 1111 (1996), *citing* Mark I. Taragin et al., "The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims," 117 *Annals Internal Med.* 780, 782, 780 (1992).

[10] Philip G. Peters, Jr. "The Role of the Jury in Modern Malpractice Law," 87 *Iowa L. Rev.* 909, 922 (2002), http://papers.ssrn.com/sol3/Papers.cfm?abstract_id=310681.

[11] *Id.* at 924-25, citing Kevin M. Clermont & Theodore Eisenberg, "Trial by Jury or Judge: Transcending
Empiricism," 77 *Cornell L. Rev.* 1124, 1137, 1174 (1992).

[12] Allen Pusey, "Judges Rule in Favor of Juries: Surveys by Morning News, SMU Law School Find Overwhelming Support for Citizens' Role in Court System," *Dallas Morning News*, May 7, 2000.

[13] *Ibid*.

[14] See Kirk B. Johnson, "*A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*," 42 VAND. L. REV. 1365, 1401 (1989).

Moreover, claims of efficiency and speed of process are belied by almost every other alternative compensation system, each of which is plagued with a host of bureaucratic, cost and political capture problems. For example:

The Vaccine Injury Compensation Program (VIC)

VIC was created by federal statute, the National Childhood Vaccine Injury Act of 1986, and went into effect on October 1, 1988.[15] Unlike Health Courts, it is based on a no-fault compensation system although many argue that the Program has been co-opted by political forces and turned into a victim's nightmare.[16] Critics contend that the process is heavily weighted against the injured parties, the process takes too long, and the HHS Secretary has removed too many injuries from the table.[17]

Agency determinations to remove certain injuries from the covered table, and limit the statute of limitations have foreclosed many claims.[18] These determinations usually cannot be reviewed or appealed. Once a claim or injury is removed from the table, the element of no-fault is also removed. The claimant is then left with the frustrating task of litigating fault in an administrative setting without the full procedural safeguards of civil courts to guide the litigation. Personal anecdotes of those who have attempted to utilize the system describe waits of more than ten years and an increasingly adversarial nature to the "no-fault" proceedings.[19] Even with the morphing of the Program into an increasingly fault-based standard, the Vaccine Program still contemplates a no-fault arena for certain injuries. The Program's slow political capture and subsequent demise as an adequate alternative for victims should, if anything, serve as a loud warning as to the vulnerability of a fault-based alternative tribunal to address injured medical consumers.

Workers Compensation

State legislatures have been chipping away at worker's compensation systems at an alarming rate almost since its inception, in direct response to the requests of insurance carriers and businesses.[20] In many states, the process workers must go through to make claims and receive compensation has become longer, less efficient, and ultimately less successful in terms of its original goals.[21] According to one legal scholar who studies workers compensation, "injured workers often face denials and delays of apparently

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[15] National Childhood Vaccine Injury Act of 1986, P.L. 99-660.

[16] Id.; see also Statement of the National Vaccine Information Center Co-Founder & President Barbara Loe Fisher, September 28, 1999, House Oversight Hearing, "*Compensating Vaccine Injury: Are Reforms Needed?*" (discussing the unilateral power DHHS has to change the burdens of proof and other restrictions); Derry Ridgway, "*No-Fault Vaccine Insurance: Lessons from the National Vaccine Injury Compensation Program*," 24 J. HEALTH POL'Y & L. 59, 69 (1999)("Lessons")(describing how the program originally awarded many more claims, until the Department of Justice decided to aggressively argue against claimants.)

[17] See Elizabeth C. Scott, "*The National Childhood Vaccine Injury Act Turns Fifteen*," 56 FOOD & DRUG L.J. 351 (2001)(stating that, as of 2001, 75 percent of claims were denied after long and contentious legal battles taking an average of 7 years to resolve).

[18] See, e.g., Lessons, supra note 38, at 86.

[19] See Elizabeth C. Scott, "*The National Childhood Vaccine Injury Act Turns Fifteen*," 56 FOOD & DRUG L.J. 351, 358-363 (2001)(discussing "horror stories about the length of time it takes them to process the case and receive compensation . . . [and] families who've gone bankrupt trying to meet their children's medical and emotional needs while going through the system." Also noting the adversarial nature of these "combative mini-trials," where, even after the decision to compensate is made, veteran DOJ litigators "fight over minutia like the future cost of diapers in a certain state.")

[20] See "Worker's Comp: Falling Down on the Job," Consumer Reports, 2000 (discussing the legislative reforms of the 1990s and the resulting profits for worker's compensation insurance providers).

[21] See Hammond and Kniesner, "The Law and Economics of Worker's Compensation," Rand Institute for Civil Justice, 1980.

legitimate claims, high litigation costs, discrimination, and harassment by employers and coworkers.… [M]any reports suggest that recent reforms have substantially increased injured workers' financial burdens." [22]

It is clear that workers who are permanently disabled are not getting enough compensation and the compensation duration is too short. Data consistently shows that a worker injured at the workplace earns significantly less than before the injury, even after returning to work. For example, according to one Rand Institute for Civil Justice study, "permanent partial disability claimants injured in 1991-1992 [in California] received approximately 40 percent less in earnings over the four to five years following their injuries than did their uninjured counterparts."[23] Moreover, "for workers with minor disabilities, benefits replace a small fraction of lost wages." [24] An earlier Rand ICJ report, released in 1991 found that "injured workers recovered a lower percentage of their accident costs than all accident victims (54.1%), and that workers' compensation only compensated about 30% of the costs of long-term disabilities from work accidents."[25]

Virginia's Birth-Related Neurological Injury Compensation Program

The *Richmond Post-Dispatch* newspaper reported on this program several years ago, finding, "Children born in Virginia with catastrophic neurological injuries are promised lifetime medical care by the birth-injury program. But these children and their families also have been forced to absorb stunning disparities in program benefits because of shifting priorities and cost reductions over which they had no control or voice…. 'The program can end up providing very little,' said Christina Rigney, referring to the minimal benefits her family received in the face of her son's traumatic birth and brief life. 'We believed there was negligence involved, but nothing ever came of it.'" Her son died three years after he was severely injured due to oxygen loss during birth. Because of the birth injury law, the family couldn't file a malpractice suit, the obstetrician was never even asked to explain what happened, and the family could learn nothing from illegible notes that failed to account for long periods of time. Families of two other brain-injured infants delivered by the same obstetrician faced the same limits on their ability to learn what happened, or seek to show he was negligent. He is facing a lawsuit, however, for a fourth case in which a woman giving birth bled to death after delivering a healthy baby.[26] National birth-injury experts have reportedly expressed fear about Virginia becoming a safe harbor for bad doctors due to this law.[27]

SECRECY ABOUT ERRORS AND INJURIES WILL CONTINUE UNDER THESE PROPOSALS

It is misguided to think that fear of litigation is the only, or even principal, reason that doctors and hospitals do not report errors. As noted in the May 11, 2006 *New England Journal of Medicine* article, "There are many reasons why physicians do not report errors, including a general reluctance to communicate with patients and a fear of disciplinary action or a loss of position or privileges."[28]

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[22] McCluskey, Martha T., "The Illusion of Efficiency in Workers' Compensation "Reform," 50 Rutgers L. Rev 657, 699-700, 711 (1998) n. 158, 159, 160

[23] See, Rand Research Brief, "Compensating Permanent Workplace Injuries," 1998.

[24] Id.

[25] McCluskey, Martha T., "The Illusion of Efficiency in Workers' Compensation "Reform," 50 Rutgers L. Rev 657, 699 (1998) n. 156, 157 (citing Deborah R. Hensler et Al., *Compensation For Accidental Injuries In The United States* 107 fig.4.8 (1991)).

[26] Bill McKelway, "Brain-Injury Program's Outlook Dim; Cost Savings For Doctors Meant Less For Children," *Richmond Times Dispatch*," Nov, 16, 2002.

[27] *Ibid.*

[28] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.

hospitals have some of the strongest protections from liability in the nation, since nearly all fall under the state's charitable immunity laws that cap their liability at $20,000.[29] Yet, even though they run little risk of liability for errors, "statistics suggest, and leading experts confirm, that doctors and hospitals around Boston — widely considered the medical capital of the world — are vastly underreporting their mistakes to regulators and the public."[30] According to a February 2003 *Boston Magazine* article:

> In 2001, Massachusetts hospitals reported 982 serious incidents, or medical errors, to state regulators, up from 636 five years earlier, but still an average of just three reports per day. In New York State, by comparison, hospitals submitted nearly 30,000 reports, or 82 per day. In fairness, that disparity is mostly due to the different ways the states define a medical error: New York studies every little complication; Massachusetts, only major incidents. Still even New York is criticized for disclosing fewer medical errors than actually occur, and with a population only three times that of Massachusetts, it is reporting more than 30 times as many. One doctor who was a member of a Massachusetts oversight committee says statistics show there should be 10 reports of medical errors per 100 hospital beds each year. In fact, hospitals in this state are disclosing roughly three. Even when they are reported, one Harvard School of Public Health professor says, many medical errors are barely investigated because of a lack of resources.[31]

Under the birth-injury program in place in Virginia, obstetricians are not asked to explain what happened, and the family may never learn anything about what caused a catastrophic injury. According to news reports, not a single case in the program's 15-year history has produced a disciplinary action against a hospital or doctor, even though those cases "pose a high risk for findings of negligence against doctors, nurses and hospitals."[32] One mother of a daughter with cerebral palsy and other severe disabilities testified before the Virginia House that the program "has evolved from a model of care for severely disabled children to . . . safe haven for physicians and hospitals who, in some cases, are directly responsible for these catastrophic injuries."[33]

THE IMPORTANCE OF LITIGATION FOR PATIENT SAFETY

As stated earlier, the May 11, 2006, *New England Journal of Medicine* article argued that litigation against hospitals improves the quality of care for patients.[34] In a March 5, 1995, *New York Times* article, Dr. Wayne Cohen, then-medical director of Bronx Municipal Hospital, said, "The city was spending so much money defending obstetrics suits, they just made a decision that it would be cheaper to hire people who knew what they were doing."[35]

Patients have suffered tremendously as a result of dangerous or incompetent health care providers, hospitals, HMOs, and nursing homes. Many unsafe practices were made safer only after lawsuits were filed against those responsible. In other words, lawsuits

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[29] Mass. Gen. Laws ch. 231, § 85K (2003).
[30] Doug Most, "The Silent Treatment," *Boston Magazine*, Feb. 2003.
[31] *Ibid.*
[32] Bill McKelway, "Brain Injuries Spur No Action; Case Review, Required by Law, Is Not Being Done, Va. Study Found," *Richmond Times Dispatch*, Jan. 14, 2003.
[33] Bill McKelway, "Panel Approves Bill on Birth Injuries; Would Expand Benefits and Notification Rights," *Richmond Times Dispatch*, Jan. 29, 2003.
[34] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.
[35] Dean Baquet and Jane Fritsch, "New York's Public Hospitals Fail, and Babies Are the Victims," *New York Times,* March 5, 1995.

protect us all, whether or not we ever go to court. Moreover, the amount of money saved as a direct result of this litigation — injuries prevented, health care costs not expended, wages not lost, etc. — is incalculable. Some examples of these cases include:

- **Failure to properly monitor patient.**

FACTS: Marilyn Hathaway suffered brain damage after an anesthesiologist failed to monitor her cardiopulmonary status during surgery. In 1983, Hathaway sued the physician. The jury verdict was for $5 million in damages.[36]

EFFECT: According to the book *Silent Violence, Silent Death*, "After having to pay repeated medical malpractice claims arising from faulty anesthesia practices ... Arizona's malpractice insurance companies took action. For example, the Mutual Insurance Company of Arizona, which insures over 75 percent of the state's physicians, began levying a $25,000 surcharge on insurance premiums for anesthesiologists against whom claims had been made because constant monitoring of the patient was not performed during general anesthesia. As a result of litigation, adequate anesthesia monitoring during surgery has become a standard medical practice in Arizona."[37]

- **Tube misinsertion caused death.**

FACTS: Rebecca Perryman was admitted to Georgia's DeKalb Medical Center after suffering from kidney failure. While undergoing dialysis, a catheter inserted in her chest punctured a vein, causing her chest cavity to fill with blood. Perryman suffered massive brain damage and lapsed into a coma. She died two weeks later. Perryman's husband Henry filed suit against DeKalb and its Radiology Group, as well as the doctor who failed not only to spot the misplaced catheter in Perryman's chest x-ray but also to quickly respond to the victim's excessive bleeding. DeKalb and the Radiology Group settled before trial for an undisclosed amount; a jury awarded $585,000 against the doctor.[38]

EFFECT: "After the award, the radiology department instituted new protocol for verifying proper placement of catheters." [39]

- **Emergency room failed to diagnose heart disorders.**

FACTS: Three Air Force servicemen died after being discharged from the emergency room without proper examination. Though each had a history of heart problems and displayed classic symptoms of heart disorder, all three were misdiagnosed with indigestion.[40]

EFFECT: "As a result of malpractice litigation, the Air Force investigated the deaths and instituted stringent new requirements for diagnostic testing ... These

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[36] *Frank v. Superior Court of the State of Arizona et al.,* 150 Ariz. 228 (1986).

[37] Rosenfeld, Harvey, *Silent Violence, Silent Death*. Washington, DC: Essential Books (1994), p. 56, citing Holzer, James F., "The Advent of Clinical Standards for Professional Liability," *Quality Review Bulletin*, Vol. 16, No. 2 (February 1990).

[38] *Perryman v. Rosenbaum et al.*, No. 86-3453 (DeKalb County Super. Ct., Ga., verdict June 5, 1991).

[39] Koenig, Thomas & Michael Rustad, *In Defense Of Tort Law*. New York: New York University Press (2001), citing letter correspondence from W. Fred Orr, III, Henry Perryman's attorney, dated April 26, 1994.

[40] Rosenfeld, Harvey, *Silent Violence, Silent Death*. Washington, DC: Essential Books (1994), pp. 567, citing *Downey v. U.S.*, No. MCA 84-2012/RV (N.D. Fla., filed 1984), *Evans v. U.S.* and *Dutka v. U.S .Evans* and *Dutka* were filed as administrative complaints but settled prior to filing of complaints in federal district court. Rosenfeld, Harvey, *Silent Violence, Silent Death*. Washington, DC: Essential Books (1994), n. 153, citing telephone interview with C. Wes Pittman, one of the servicemen's attorneys.

procedures are now standard practice at Air Force medical facilities throughout the world."[41]

- **Newborns left in nursery without supervision.**

FACTS: In September 1982, James Talley was born at Doctors Hospital in Little Rock, Arkansas. He was left alone for 35 minutes, 10 to 15 of which he stopped breathing. When a nurse came to check on him, his heart had stopped and he had turned blue. The oxygen deprivation caused permanent brain damage. The Talleys sued Hospital Corporation of America (HCA), Doctors Hospital's parent company, arguing that HCA's cost cutting procedure of reducing the number of nurses in the pediatric unit placed newborns at risk of injury or death. At trial, evidence showed that it would have cost Doctors Hospital an additional $70,000 per year per nurse to have someone in the nursery at all times and that the hospital was consistently two nurses short on the nightshift. The jury awarded $1.85 million in compensatory damages for James, $777,000 to his mother and $2 million in punitive damages.[42]

EFFECT: "As a result of this decision, HCA changed its policy on staffing pediatric units throughout its chain of hospitals, potentially saving hundreds of new lives and preventing as many injuries."[43]

- **Staffing problem endangered patients.**

FACTS: On January 26, 1998, Dr. Roberto C. Perez suffered severe brain damage after a nurse, who had been working over 70 hours a week and was just finishing an 18-hour shift, injected him with the wrong drug. Perez had been admitted to Mercy Hospital in Laredo, Texas, two weeks earlier after a fainting spell and was almost ready to be discharged. His family filed a medical malpractice suit against Mercy Hospital, among others, arguing that hospital administrators knew since 1994 that staffing problems existed yet failed to do anything about the nursing short-age. The case settled before trial, with the hospital paying $14 million.[44]

EFFECT: As part of the settlement, Mercy Hospital agreed that no nurse in the ICU would be allowed to work more than 60 hours per week.[45]

- **Bacterial infection spread to hospital roommate.**

FACTS: In 1983, 72-year-old Julius Barowski contracted a bacterial infection from a fellow patient after undergoing knee replacement surgery. His condition required 11 hospitalizations and 9 surgeries; his leg lost all mobility. As the infection spread, he suffered excruciating pain and was institutionalized for depression until his death one

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[41] Rosenfeld, Harvey, *Silent Violence, Silent Death*. Washington, DC: Essential Books (1994), p. 57, citing telephone interview with C. Wes Pittman, one of the servicemen's attorneys.

[42] "Saving The Newborn," *Trial Lawyers Doing Public Justice* (July 1987), citing *National Bank of Commerce v. HCA Health Services of Midwest, Inc.*, No. 84-160 (Saline County Cir. Ct., Ark., verdict October 6, 1986). *See also*, Rosenfeld, Harvey, *Silent Violence, Silent Death*. Washington, DC: Essential Books (1994), pp. 578.

[43] "Saving The Newborn," *Trial Lawyers Doing Public Justice* (July 1987).

[44] *Perez v. Mercy Hospital*, No. 98 CVQ 492-D3 (341st Judicial Dist., Webb County Ct., Tex., settlement October 28, 1999); *Perez v. Mercy Hospital*, No. 98 CVQ 492-D3 (341st Judicial Dist., Webb County Ct., Tex., fourth amended original petition, filed October 22, 1999)(on file with CJ&D).

[45] *Perez v. Mercy Hospital*, No. 98 CVQ 492-D3 (341st Webb County Ct., Tex., settlement October 28, 1999); *Perez v. Mercy Hospital*, No. 98 CVQ 492-D3 (341st Judicial Dist., Webb County Ct., Tex., release and settlement agreement, October 28, 1999)(on file with CJ&D).

year later. Barowski's representative filed suit, alleging that the hospital breached its own infection control standards. The jury awarded $500,000.[46]

EFFECT: "The Widmann ruling and similar cases have had a catalytic impact in health care facilities around the country. Facilities are much more attentive to the clinical importance of cleanliness in all its dimensions — handwashing, routine monitoring of infection risks, and more vigorous reviews of hospital infection control protocols." [47]

- **Inadequate monitoring led to patient's death.**

FACTS: In 1996, 78-year-old Margaret Hutcheson lapsed into a coma and died after a two-and-a-half month stay at Chisolm Trail Living & Rehabilitation Center. Hutcheson had been admitted to Chisolm for short-term rehabilitation after fracturing her hip and wrist at home. While residing at the center, she suffered severe pressure sores, malnourishment and dehydration, which required three hospitalizations. Hutcheson's family sued the facility and its personnel for wrongful death, arguing that Chisolm was understaffed and failed to follow internal procedures to ensure Hutcheson's safety. The jury awarded $25 million.[48]

EFFECT: As part of the settlement, Diversicare, the nursing home operator, "agreed to adopt a policy requiring the residents' charts be monitored on a weekly basis to ensure their needs are being met. This policy has been implemented in all 65 nursing homes owned or operated by Diversicare, and will benefit over 7,000 nursing home residents."[49]

- **Nurses feared consequences of challenging doctors' actions.**

FACTS: On April 30, 1979, Jennifer Campbell suffered permanent brain damage after becoming entangled in her mother's umbilical cord before delivery. Although a nurse had expressed concern when she noticed abnormalities on the fetal monitor, the obstetrician failed to act. Despite the doctor's unresponsiveness, the nurse never notified her supervisor or anyone else in her administrative chain of command. The child developed cerebral palsy, requiring constant care and supervision. Evidence revealed that the hospital lacked an effective mechanism for the nursing staff to report negligent or dangerous treatment of a patient. In addition, the nursing supervisor testified that an employee could be fired for questioning a physician's judgment. The jury awarded the Campbells over $6.5 million.[50]

EFFECT: "Because of this verdict and its subsequent publicity, hospitals throughout North Carolina have adopted a new protocol that allows nurses to use their specialized training and judgment on behalf of patients, without risking their jobs." [51]

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[46] *Widmann v. Paoli Memorial Hospital*, No. 85-1034 (E.D. Pa., verdict December 9, 1988). *See also*, Rosenfeld, Harvey, *Silent Violence, Silent Death*. Washington, DC: Essential Books (1994), pp. 556.

[47] Rosenfeld, Harvey, *Silent Violence, Silent Death*. Washington, DC: Essential Books (1994), pp. 556.

[48] *Olson et al. v. Chisolm Trail Living & Rehabilitation Center et al.*, No. 98-0363 (Caldwell County Ct., Tex., verdict August 26, 1999). *See also*, Osborn, Claire, "Family of care center resident who died awarded $25 million," *Austin AmericanStatesman*, August 27, 1999.

[49] *Texas Reporter Soele's Trial Report* (November 1999). *See also*, Malone, Julia, "Lawyers Filling Gap Left By Regulators," *Palm Beach Post*, September 25, 2000.

[50] *Campbell v. Pitt County Memorial Hospital, Inc.*, 84 N.C. App. 314 (1987). *See also*, Mahlmeister, Laura, "The perinatal nurse's role in obstetric emergencies: legal issues and practice issues in the era of health care redesign," *Journal of Perinatal & Neonatal Nursing* (December 1996); Rosenfeld, Harvey, *Silent Violence, Silent Death*. Washington, DC: Essential Books (1994), p. 57.

[51] Rosenfeld, Harvey, *Silent Violence, Silent Death*. Washington, DC: Essential Books (1994), p. 57.

- **Patient prescribed incorrect chemotherapy dosage.**

FACTS: When 41-year-old Vincent Gargano was diagnosed with testicular cancer in 1994, he was given a 90 percent to 95 percent chance of survival. On May 26, 1995, he entered the University of Chicago Hospitals to undergo his last phase of chemotherapy. For four consecutive days Gargano received a dosage that was four times the needed amount, a mistake that went undetected by at least one doctor, two pharmacists and four nurses until four overdoses had already been administered. Hospital records showed that the prescribing doctor wrote the incorrect dosage and that three registered nurses failed to double-check the prescription against the doctor's original order. As a result, Gargano suffered hearing loss, severe kidney damage, festering sores and ultimately the pneumonia that caused his death the following month. The case settled for $7.9 million.[52]

EFFECT: The hospital implemented new policies to ensure that doctors and nurses better document and cross-check medication orders.[53]

SOME solutions to reduce medical errors

There is no doubt that deaths and injuries due to medical malpractice are substantial. In late 1999, the National Academy of Sciences Institute of Medicine (IOM) published *To Err is Human; Building a Safer Health System.* The study makes some striking findings about the poor safety record of U.S. hospitals due to medical errors.[54] For example, between 44,000 and 98,000 deaths occur each year in U.S. hospitals due to medical errors, the higher figure extrapolated from the 1990 Harvard Medical Practice study of New York hospitals. Even using the lower figure, more people die due to medical errors than from motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).

A recent survey found, "[e]ighty percent of U.S. doctors and half of nurses surveyed said they had seen colleagues make mistakes, but only 10 percent ever spoke up." Moreover, "fifty percent of nurses said they have colleagues who appear incompetent" and "[e]ighty-four percent of physicians and 62 percent of nurses and other clinical care providers have seen co-workers taking shortcuts that could be dangerous to patients." Doctors and nurses do not talk about these problems because "people fear confrontation, lack time or feel it is not their job."[55]

There is much that can and should be done. Unfortunately, too little is being done to weed out the small number of doctors responsible for most malpractice. As the *New York Times* reported,

> Experts retained by the Bush administration said on Tuesday that more effective disciplining of incompetent doctors could significantly alleviate the problem of medical malpractice litigation.

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[52] Berens, Michael J., "Problem nurses escape punishment; State agency often withholds key details of violations," *Chicago Tribune*, September 12, 2000; "Notable settlement," *National Law Journal*, November 8, 1999, citing *Gargano v. University of Chicago Hospitals*, 95 L 10088 (Cook County Cir. Ct., Ill., settled October 7, 1999); "University hospital to pay $7.9 million for fatal doses of chemotherapy," *Associated Press*, October 8, 1999; "Cancer Patient in Chicago Dies After Chemotherapy Overdose," *New York Times*, June 18, 1995; "Cancer Patient Dies After Chemo Overdose," *Legal Intelligencer*, June 16, 1995.

[53] Berens, Michael J. & Bruce Japsen, "140 Nurses' Aides Fired By U. Of C. Hospitals; Registered Nurses Fear Work Burden," *Chicago Tribune*, October 31, 2000; Berens, Michael J., "U. Of C. To Pay $7.9 Million In Death Of Cancer Patient," *Chicago Tribune*, October 8, 1999.

[54] Kohn, Corrigan, Donaldson, Eds., *To Err is Human; Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, DC (1999).

[55] "Survey: 80 percent of doctors witness mistakes; But only 10 percent report errors or poor judgment, "*Reuters,* January 26, 2005. http://www.msnbc.msn.com/id/6872715/.

> As President Bush prepared to head to Illinois on Wednesday to campaign for limits on malpractice lawsuits, the experts said that states should first identify those doctors most likely to make mistakes that injure patients and lead to lawsuits.
>
> The administration recently commissioned a study by the University of Iowa and the Urban Institute to help state boards of medical examiners in disciplining doctors.
>
> "There's a need to protect the public from substandard performance by physicians," said Josephine Gittler, a law professor at Iowa who supervised part of the study. "If you had more aggressive policing of incompetent physicians and more effective disciplining of doctors who engage in substandard practice, that could decrease the type of negligence that leads to malpractice suits.'"
>
> Randall R. Bovbjerg, a researcher at the Urban Institute, said, "If you take the worst performers out of practice, that will have an impact" on malpractice litigation.[56]

Public Citizen's Health Research Group has made similar findings for many years.[57] The group found that only one-half of 1 percent of 770,320 licensed medical doctors face any serious state sanctions each year. "Too little discipline is still being done," the report said. "2,696 total serious disciplinary actions a year, the number state medical boards took in 1999, is a pittance compared to the volume of injury and death of patients caused by negligence of doctors…. Though it has improved during the past 15 years, the nation's system for protecting the public from medical incompetence and malfeasance is still far from adequate."

Other problems that can be addressed include:

Safer RN staffing ratios. A 2002 study in the Journal of the American Medical Association found that patients on surgical units with patient-to-nurse ratios of 8:1 were 30 percent more likely to die than those on surgical units with 4:1 ratios.[58]

Reduce continuous work schedules. According to studies published in the October 28, 2004, issue of the *New England Journal of Medicine*, "The rate of serious medical errors committed by first-year doctors in training in two intensive care units (ICUs) at a Boston hospital fell significantly when traditional 30-hour-in-a-row extended work shifts were eliminated and when interns' continuous work schedule was limited to 16 hours, according to two complementary studies funded by the National Institute for Occupational Safety and Health (NIOSH) and the Agency for Healthcare Research (AHRQ). Interns made 36 percent more serious medical errors, including five times as many serious diagnostic errors, on the traditional schedule than on an intervention schedule that limited scheduled work shifts to 16 hours and reduced scheduled weekly work from approximately 80 hours to 63. The rate of serious medication errors was 21 percent greater on the traditional schedule than on the new schedule.[59]

Better technology in hospitals to provide better care with greater consistency. A handful of hospitals are starting to use technology to make prenatal care and delivery

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[56] Robert Pear, "Panel Seeks Better Disciplining of Doctors," *New York Times,* January 5, 2005.

[57] *See, e.g.,* Sidney Wolfe et al., *20,125 Questionable Doctors*, Public Citizen Health Research Group, Washington, DC (2000).

[58] L.H. Aiken et al., "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," 288 JAMA 1987 (Oct. 23/30, 2002).

[59] "Interns' Medical Errors Affected by Work Schedules," November 15, 2004, http://www.insurancejournal.com/news/national/2004/11/15/47660.htm

safer. These hospitals are using computer software that improves monitoring and treatment.[60]

CONCLUSION

Under Health Courts, the long-standing and fundamental right to trial by jury is eliminated for medical malpractice victims. Instead, patients are forced into an alternative system without juries, without any accountability mechanisms, without procedural safeguards, and without any meaningful appeals process. These hardships, coupled with the burden of having to prove fault, render the injured claimant virtually powerless and at the mercy of the insurance and hospital industries.

Safety suffers when systems are not designed to reflect the full costs of accidents. Our objectives should be deterring unsafe and substandard medical practices while safeguarding patients' rights. Indeed, our goal must be to reduce medical negligence. This is not the time to establish a new process, which will only protect incompetent doctors even more from meaningful liability exposure and scrutiny, including the most egregiously reckless health care providers.

MR. DEAL. Thank you.

Ms. Niro.

MS. NIRO. Thank you, Mr. Chairman, for the opportunity to present the views of the American Bar Association, the ABA.

My name is Cheryl Niro. I have been an attorney for almost 25 years. I am one of the earliest attorneys in the country, and certainly in the State of Illinois, to become a mediator and arbitrator. I have been both a student and a teaching assistant at the Harvard Law School of Mediation and Negotiation Training programs. I have successfully mediated well over 100 cases. I have trained judges and lawyers to mediate cases. But most importantly, I have worked with healthcare institutions to design courses and ADR systems and have taught their professionals how to use negotiation and mediation skills to resolve healthcare disputes with patients and their families on site, just one program that has the potential for dramatically impacting and lowering the number of subsequent filings of malpractice suits. I have never filed a plaintiff's medical malpractice suit in my career, although I have resolved many of them.

My written testimony focuses largely on the issues presented by the health court models discussed today, but I would just like to highlight the ABA's concerns about them.

The preeminent concern is that the model would remove the injured patients' rights protected by the Seventh Amendment of our Constitution to have a trial by jury. Injured persons would therefore lose the protections of the rules of evidence and the rules of procedure, which exist to assure that parties are treated equally in the court system. While proponents say that the health court model would be constitutional because it is similar to the workmen's compensation model, there is a

[60] Margaret Ramirez, "System Checks Steps in Care," *Newsday*, Oct. 7, 2003.

significant difference, and that is injured workers do not have to prove liability where injured patients would still have that burden. They would not be in a court of law, but they would have a burden of proof as if they were in a court.

There are very fine alternatives that exist currently today that do not damage an injured patient's right to a trial by jury and judge. Alternative dispute resolution, or ADR, as we call it, has been used across the country, and quite successfully. We certainly do not need to create a system with this administrative, bureaucratic tangle when we have got a system currently that looks like this.

The circle here at the bottom, below the trial court and the appellate court, is the world of alternative dispute resolution. I would like to take just a moment to explain some of these processes.

The most simple is negotiation. A convening of the parties to sit across the table from each other, or even better yet, to sit next to each other at the table and try to cooperatively work out a resolution to the dispute. If they fail, they may agree to bring in a mediator. The mediator, also selected by agreement of the parties, is neutral, has no authority to impose a resolution. The mediator is there to assure that the process is fair and assists the parties to continue their negotiations, often using sophisticated skills in getting them beyond impasse and keeping the parties at the table until a solution is found.

There are summary jury trials where the parties may present their cases to a privately-obtained neutral to act as judge, which allows the parties to see how a judge and jury may likely rule. With that information, they can conduct further negotiation armed with the information from the likelihood of outcome in trial. Only mutual evaluation is presenting both sides' information to an expert, private, neutral, who makes very instructive and informative assessments of the case in the most likely outcomes, both in liability and damages.

All of these, and many more processes, are currently available and in use around the country and all have the integrity necessary to pass constitutional muster. They are all voluntary, truly voluntary. They may be used, in effect, custom designs to fit the unique circumstances of the cases.

At this point, I just want to mention that neither the health court proposal nor the early offer proposals are truly voluntary. In the healthcare bill, patients would be forced into the health court system with no access to the court. In early offer, the decision to refuse the offer made by the patient would put the injured patient in what the offer concedes would be an unattainable burden of proof in liability of gross negligence beyond the shadow of a doubt, which is simply no choice at all.

The ABA is very concerned that any alternative to our court system must be completely free of coercion, truly voluntary, and preserve the rights of the patient. ADR offers both. I urge you to make the contribution to invest in greater use, greater understating, greater cooperation, greater participation in developing these alternatives so that they, which are consistent with patients' rights, may be used.

I have brought for you two magazines today, which were created on dispute resolutions used in the healthcare industry. I believe some of the materials are in your packages today. The ABA supports any change in the access to alternative dispute resolution that is voluntary, that preserves the rights of the patients, and opposes any bill that would remove those essential rights from any of our citizens.

I am grateful to have had the opportunity to discuss this with you this morning and would be honored to take your questions and continue the dialogue.

[The prepared statement of Cheryl Niro follows:]

PREPARED STATEMENT OF CHERYL NIRO, PARTNER, QUINLAN & CARROLL, LTD, ON BEHALF OF AMERICAN BAR ASSOCIATION

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to present the views of the American Bar Association (ABA) on "Innovative Solutions to Medical Liability." My name is Cheryl Niro, and I am an incoming member of the Standing Committee on Medical Professional Liability and a member of the House of Delegates of the ABA. I am appearing on behalf of the ABA at the request of its President, Michael Greco.

I was an early proponent of alternative dispute resolution and sought the best education possible in the areas of mediation, negotiation and arbitration. I have been certified and trained by the founders of these fields. I began at The Atlanta Justice Center, one of the first three mediation programs in the nation. I was a student and teaching assistant at the Harvard Law School mediation and negotiation training programs.

In 1992, I was a founding director of a dispute resolution training program funded by a joint grant from the US Departments of Education and Justice. That program became the National Center for Conflict Resolution Education and trained thousands of educators, teachers, parents and students to create Peer Mediation Programs in schools and other youth-serving organizations across the country.

I have served on the ABA Section of Dispute Resolution Council and have conducted skills-based training programs for hospital professionals so that they may use these skills to resolve medical care disputes cooperatively with patients and their families. I have never filed a plaintiff's medical malpractice claim in my career.

I testify here today as a proud representative of the ABA, a lawyer interested in improving our legal system and an American citizen committed to our tradition of fairness and justice.

For decades the ABA has supported the use of, and experimentation with, voluntary alternative dispute resolution techniques as welcome components of the justice system in the United States, provided the disputant's constitutional and other legal rights and remedies are protected. The ABA strongly supported the alternative dispute resolution movement in the United States through Committees and in 1993 it created a Section of

Dispute Resolution. The Section promotes efforts that focus on education, experimentation and implementation of alternatives to litigation that resolve disputes economically and without taxing limited courtroom resources.

As a result of the work of our Dispute Resolution professionals, and leaders in that field across the country, the number of courts utilizing these methods increases daily. Successful programs are replicated, new understanding of the potential offered by these voluntary processes is achieved, and greater numbers of judges, lawyers and clients find these alternatives acceptable tools with which legal disputes may be resolved. Over the past fifteen years, the ABA has contributed significantly to the development of the field by creating ethical standards, best practices training and scholarship to this emerging practice. Additionally, the ABA House of Delegates has adopted policy directed at ensuring the efficacy and integrity of these voluntary alternatives to litigation.

Mediation, by definition, is a voluntary process whereby disputants may work together, with the assistance of a trained neutral facilitator, to resolve their dispute. Mediation, as it is known and practiced worldwide, is not a mandatory process. Where disputants are compelled to mediate, the compulsion is only to engage in a mediation process in good faith. Agreements cannot be compelled. Likewise, the ethical use of arbitration requires that parties knowingly agree to engage in the process.

Specific to the area of medical malpractice, the ABA endorses the use of voluntary negotiation, mediation, and settlement agreements. In addition, the ABA recognizes the use of arbitration as an option for resolving these types of disputes under circumstances whereby the agreement to arbitrate is entered into only on a voluntary basis after a dispute has arisen and only if the disputant has full knowledge of the consequences of entering into such an arrangement.

The American Bar Association has reviewed, as part of ongoing efforts to improve the operation of our legal system, proposals related to the area of liability of health care providers. One such proposal is the creation of "health courts." Under the proposed "health court" system, an administrative agency would oversee the operation of specialized "courts" where medical malpractice cases would be heard by persons possessing experience in the health care field rather than judges and juries. Under this proposal, medical negligence litigation cases would be removed from the court system and the protection of the time-tested rules of procedure and evidence. The parties would be allowed to be represented by attorneys. There would be no juries. Expert witnesses would by hired by "health courts," not by the injured patient. Injured patients would be compensated according to a schedule of awards. Patients injured by medical negligence would be denied the right to request a trial by jury and the right to receive full compensation for their injuries.

Proponents of the "health courts" proposal say it is modeled on the Workers' Compensation system. But there are major differences between the two systems. It is unlike the Workers' Compensation system in that injured patients would still be required to prove fault on the part of a defendant. A similar burden to prove fault is not imposed on an injured worker in a Workers' Compensation case. Importantly, the Workers' Compensation system balances the loss of the right to bring an action in court with a guaranteed award that is not fault-based. In the "health court" scheme, injured patients are forced to give up the right to bring an action in a court with no guarantee of an award. Injured patients would be required to prove that their injuries are "the result of a mistake that should have been prevented." Proponents call this the "avoidability standard," which includes injuries "that would not have happened were optimal care given." This is not a "no fault" standard as in the Workers' Compensation field, nor is it a strict liability standard.

The "health court" scheme and other proposals for administrative tribunal schemes also include the creation of a schedule for the assessment of damages and would cover both economic and non-economic damages. Such a schedule is inappropriate in medical

malpractice cases where a fixed, rigid assessment would treat all patients with similar injuries the same. Would it be fair to award a pre-determined award for negligence that results in a paralyzed hand for a surgeon, or the loss of vision for an artist? The plan assumes that consensus would produce an annually adjusted schedule based upon research on similar schedules in the U.S. legal system and abroad. Proponents urge the comparison to Sweden and Denmark for regularizing the value of American injuries. The efficacy of that approach is doubtful, because those nations have health and welfare benefits that are paid for by their governments before consideration of the injury claim take place.

By establishing a schedule of injuries/pay-outs, the "health court" scheme would impose a de facto cap on non-economic damages in injury claims. The plan contemplates Presidential and congressional appointees to establish the schedule, but there is no guarantee that the Commission would be balanced, nor that the schedule would provide fair and just compensation for the injured patients. Caps on non-economic damages work to the disadvantage of women, children and the elderly. Thirteen states have found caps unconstitutional. Courts and juries have a long tradition of fashioning individualized, customized damage awards to fit the unique circumstances of each case.

Thus, in February, 2006, the ABA adopted as policy the following resolution:

> RESOLVED, That the American Bar Association reaffirms its opposition to legislation that places a dollar limit on recoverable damages that operates to deny full compensation to a plaintiff in a medical malpractice action.
>
> RESOLVED, That the American Bar Association recognizes that the nature and extent of damages in a medical malpractice case are triable issues of fact (that may be decided by a jury) and should not be subject to formulas or standardized schedules.
>
> FURTHER RESOLVED, That the ABA opposes the creation of health care tribunals that would deny patients injured by medical negligence the right to request a trial by jury or the right to receive full compensation for their injuries.

The ABA firmly supports the integrity of the jury system, the independence of the judiciary and the right of consumers to receive full compensation for their injuries, without any arbitrary caps on damages. It is for these reasons that the ABA opposes the creation of any "health court" system that undermines these values by requiring injured patients to utilize "health courts" rather than utilizing regular state courts in order to be compensated for medical negligence.

As stated above, ABA policy has long endorsed the use of alternatives to litigation for resolution of medical malpractice disputes only when such alternatives are entered into on a voluntary basis and only when they are entered into after a dispute has arisen. Instead of creating and mandating the use of "health courts," the ABA advocates the use of voluntary arbitrations, mediations, and settlement conferences, all of which are appropriate means of alternative dispute resolution.

There are exciting new programs that demonstrate the efficacy of the use of alternative methodologies. One such program is at the Rush Presbyterian Hospital in Chicago, run by former judges and personal friends of mine. The Rush Mediation Program has successfully resolved more than 80% of filed claims. It is a voluntary and confidential mediation program. The mediator has no power to force the parties to agree on settlement. The mediator (or team of two mediators) has no interest in the outcome and is purely neutral. The program has demonstrated that voluntary mediation can save money for all parties, save time, settle cases and preserve the patient's right to a trial by jury.

Our legal system, the most respected in the world, has procedural safeguards that have evolved over centuries. The proposals for "health courts" contain little information on how the system would actually work. Unanswered are questions about how patients would obtain information and/or what kind of discovery would be permitted. The plan does specify that the "health court," not the injured patient, would hire expert witnesses, which is another departure from current practice. It appears that health care providers get an "opt in" opportunity, but patients have no corresponding right to "opt out." Patients may be in the position of being forced to sign agreements to use the "health court" with their HMO or health care provider before they receive treatment. More information is clearly required to obtain any clarity on the basic fairness that may be present or lacking under the "health courts" proposal.

I would be remiss if I did not mention the obvious problem contained within our Constitution in the Seventh Amendment. "In suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury shall be otherwise reexamined in a Court of the United States, than according to the rules of the common law." Proponents argue that because the Workers' Compensation system is Constitutional, that the "health courts" proposals would be as well. The problem with this reasoning, as pointed out above, is that the Workers' Compensation system was effectively balanced in providing a certain award without the burden of establishing that a mistake has been made that should have been prevented. The schedule of benefits may also be found unconstitutional if it is deemed to be caps on damages in disguise.

Proponents of "health courts" argue that juries are not capable of understanding medical malpractice cases. There is no evidence that this is the case. In fact, empirical studies have demonstrated that juries are competent in handling medical malpractice cases. Duke University School of Law Professor Neil Vidmar's 1995 extensive study of juries found that:

> [o]n balance, there is no empirical support for the propositions that juries are biased against doctors or that they are prone to ignore legal and medical standards in order to decide in favor of plaintiffs with severe injuries. This evidence in fact indicates that there is reasonable concordance between jury verdicts and doctors' ratings of negligence. On balance, juries may have a slight bias in favor of doctors.[1]

In addition, he concludes at page 259 of his 1995 publication that research "does not support the widely made claims that jury damage awards are based on the depth of the defendants' pockets, sympathies for plaintiffs, caprice, or excessive generosity." A survey of studies in the area by University of Missouri-Columbia Law Professor Philip Peters, Jr., published in March 2002 likewise found that:

[t]here is simply no evidence that juries are prejudiced against physician defendants or that their verdicts are distorted by their sympathy for injured plaintiffs. Instead, the existing evidence strongly indicates that jurors begin their task harboring sympathy for the defendant physician and skepticism about the plaintiff.[2]

A May 2005 Illinois study conducted in my home state by Professor Vidmar also concluded that there was no basis for the argument that runaway verdicts were responsible for increases in malpractice premiums.[3]

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[1] Neil Vidmar, Medical Malpractice and the American Jury: Confronting the Myths about Jury Incompetence, Deep Pockets and Outrageous Damage Awards 182 (Univ. of Michigan Press 1998) (1995).

[2] Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 934 (2002).

[3] Neil Vidmar, *Medical Malpractice and the Tort System in Illinois*, 93 ILLINOIS BAR JOURNAL 340 (2005).
The complete study may be found at this link: http://www.isba.org/medicalmalpracticestudy.pdf

Our legal system has served our nation well. Our lawyers and judges have been protecting the Constitution and the rights it contains, and have made our democracy the envy of the world. As a bar president, I have had the opportunity to visit nations where lawyers do not have the role and function of the American lawyer. I have been to Zimbabwe and Zambia, and witnessed first-hand countries where citizens can have no expectation of fairness, justice or equal treatment. I have seen the result of decades of unchecked power in the hands of leaders more interested in their own wealth than the well-being of their nations. Our system is not perfect, but our founders understood that perfection in human endeavor is not likely to be possible. I believe that is why our Constitution speaks of our national mission to create a union that is always trying to be more perfect, closer to the ideal. It is our legal system, our Constitution and our steadfast adherence to the rights of our citizens that make ours a nation of hope above all others. Lawyers strive every day to do their best work to achieve justice. Legislators have a similar duty to create laws that will produce just outcomes.

In accordance with our duty to preserve and protect our system of justice, the ABA opposes the "health courts" proposal currently being discussed. We support the use of alternatives to litigation in medical malpractice cases only when such alternatives are entered into on a voluntary basis, and only when they are entered into after a dispute has arisen. We also oppose the Workers' Compensation model in medical malpractice cases as proposed, because an injured patient loses the right to bring an action in court, but receives no guaranteed award.

Injured patients and health care providers have access to a respected court system and fair processes to resolve disputes. Any proposal that would deny access to that court system should offer a better system than our current civil justice system. The "health courts" proposal fails to meet that standard and it should be rejected.

Thank you for the opportunity to appear before you today to present the views of the American Bar Association. I would be happy to answer any questions you may have.

MR. DEAL. Thank you very much.

A very good panel.

Let me start off with the questions.

There seems to be, first of all, a disagreement within the panel. Our last two panel members, basically, are defending the status quo. I think we have heard from both sides of the committee here concern that the status quo is not achieving the overall goals that we should be achieving. I guess we need to see if we agree on what those goals ought to be.

One of the goals that would seem to me would be to put as much of the billions of dollars that are now currently spent in the overall medical liability arena, more of those dollars into the hands of the individuals who have been harmed or who are suffering, who are the victim. I hate to use that word. But does anyone disagree with that being a goal, that more of the dollars currently being expended ought to go to the person who has been injured?

I don't see anybody disagreeing with that one. All right. Good. We are doing good. Lawyers always disagree. Yes, ma'am.

MS. DOROSHOW. I mean, of course it depends where you are taking the money from.

MR. DEAL. Well, you are taking it from the lawyers' pockets. I say that facetiously, but that is really the truth.

MS. DOROSHOW. Well, I would certainly agree that much of the transaction costs of the system are due to the fact that the defendants are not acknowledging negligence and paying legitimate claims.

MR. DEAL. Well, we will get to that. That is not the question. I am going to get to that.

My second question is do you have any agreement or disagreement that the current system fosters unnecessary medical expenses by way of defensive medicine practices in an effort to avoid the consequences of the current tort system? Would you disagree with that?

MS. NIRO. I don't necessarily disagree, but I do wish to suggest that it is very difficult to solve a problem that we can't all agree on its definition. While there is a lot of money that goes into professional malpractice transactions, it is less than one-half of 1 percent, according to a study from the University of Connecticut in all of healthcare spending.

MR. DEAL. Well, that really is irrelevant. I mean, we are comparing that to open heart surgeries. You are comparing it to everything else. My point is that there is something wrong in the current system. Money is not going to the right place. Medical practice is, in part, dictated by what is going on. Mr. Wootton, I think the last two speakers were directing their comments to some of your suggestions, and I am going to ask you if you would elaborate. You said you had some charts. If you would like, try to use those.

MR. WOOTTON. Yes, thank you, Mr. Chairman.

If you want to put up the first chart, it should be the National Medical Data Center.

This is really about something that I learned from some people who are in the patient safety business, particularly working with the CDC and the FDA. The idea is that, over time, we would be able to have as many as 12 million electronic medical records that could be queried on a real-time basis, and they would be completely stripped of personally-identifiable and professionally-identifiable information. They would be available to researchers in the Government and industry and academia to look at a whole host of issues, including patient safety issues, but also in what protocols work in the treatment of disease, what kinds of areas might be promising for further research in the area.

MR. DEAL. On that, as you know, this committee has passed out a health information bill, and I don't have time now, but I would ask you, in light of your concern here, would you look at the bill we have passed out of here and give us comments as to any further things that need to be done on that health information technology bill, as it relates to this?

MR. WOOTTON. Yes, sir. Yes, sir, I will, and I also think this will provide real-time information for the agencies that are very interested in keeping track of what is going on in the health of the population, including Homeland Security, CDC, and the FDA.

If you go to the next chart, this becomes further information along with that which is going to the patient safety organizations based on the legislation that you all passed and the protections you gave last year to bring that down to the State level so that at the State level, the guidelines, which Paul mentioned and others have mentioned, become guidelines for practice. They are the taking of the nationally-accepted practices but applied by the medical community at the State level. They will become guidelines for practice but also become the basis for liability determinations, and that would be found in the State Medical Practice Commission. They would be a special resource, but not the only resource. I am very concerned about due process issues, too, and I do think that the parties have to have a right to have their own lawyers and their own experts, but having those that have a special relationship with the administrative process, I think, is very valuable. Then to have something that I discovered in talking to a lot of patient groups, and that is a distrust of the State local boards with regard to doctors who had problems that don't ever seem to have their license either suspended or revoked or not engaged in more education and get patient participation on those patient safety boards. Then something that I picked up, and actually this is something that Professor Mello speaks about, which is a problem for some in the medical community, but I think it has a lot of value, and that is the notion of enterprise liability. That is the idea that somebody has to have an incentive to deal with patient safety problems in the State. If you had something that looked like an insurance facility, like a captain insurance facility, they are actually operating in a number of States today as joint underwriting agreements, they could engage in loss reduction programs, and they would have an incentive to, because that means that the cost of their malpractice payments would be going down because you would have fewer errors.

MR. DEAL. I am going to have to interrupt you, but my time is way over.

MR. WOOTTON. Oh, I am sorry.

MR. DEAL. I am going to recognize Ms. DeGette for questions.

MR. WOOTTON. All right. Thank you, sir.

MS. DEGETTE. Thank you very much, Mr. Chairman.

This is, by far, the best panel I have ever heard on this subject in 10 years, so thank you.

And before I question, Mr. Chairman, I would ask unanimous consent to allow statements from a number of groups who have wanted to submit statements, a 24-hour period to have them submitted.

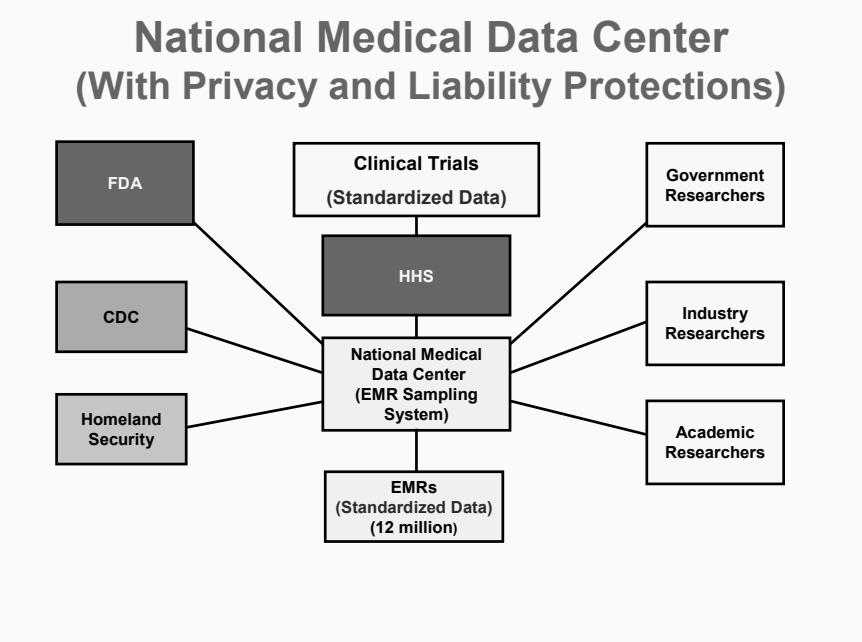
MR. DEAL. Without objection.

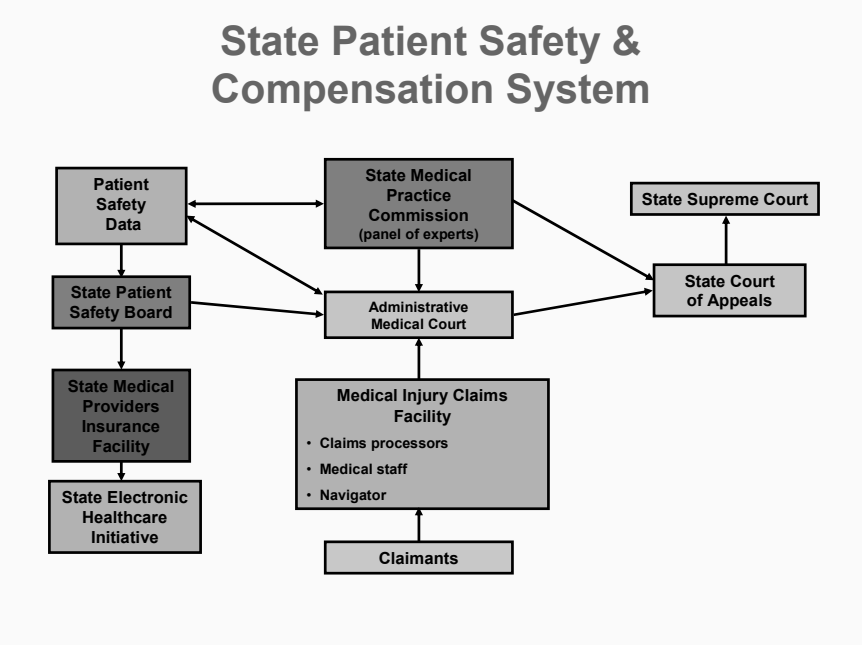
MS. DEGETTE. Thank you.

And in addition, Mr. Wootton, I would hope that you would provide us with copies of your slides, and I would ask unanimous consent that those be submitted as well.

MR. DEAL. Without objection.

[The information follows:]





MS. DEGETTE. Thank you.

Mr. Wootton, I am interested in your national medical data center proposal and your slides, although these middle-aged guys are having a hard time seeing all of the way over there, but I think it strikes all of us that that is a very good idea and one positive way that the Federal government could have a role. So thank you.

I want to ask all of the panelists, does anyone here think, for example, the health courts should be at the Federal or State level? Dr. Mello?

DR. MELLO. In my opinion, the ideal structure would be federal legislation that provides funding and parameters for State demonstration projects.

MS. DEGETTE. Okay. The health court really, and I am sure Professor O'Connell would agree with this, the tort law that is well established is at the State level, correct?

DR. MELLO. Agreed.

MS. DEGETTE. So you would want the actual health courts to be at the State level?

DR. MELLO. Yes.

MS. DEGETTE. And you really see the Federal role as providing resources to State tort systems to have these courts, correct?

DR. MELLO. I think that would be ideal.

MS. DEGETTE. Does anybody disagree where these types of reforms should be through the State level?

MR. BARRINGER. I would add that we do agree that the ideal spot for pilot projects, in particular, to take place would be at the State level, given that the States have traditionally regulated matters of insurance and malpractice. But there is also a potential for a Federal administrative pilot project. We know that Senator Cornyn and the Senate is preparing a bill that could charter federally-sponsored pilot projects. So we are, as an organization, open to a range of different approaches to pilots.

MS. DEGETTE. But would you think, then, that the Federal government would take it on? One of the big issues I have had, and frankly I think the Chairman shares some of my concerns, is that tort law and medical liability law has traditionally been the State role, and so what we have to figure it out. I always say that legislators legislate to the level they are elected. And my concern is I am not really sure that the most efficient way to resolve patient issues and to make these systems more streamlined is to suddenly create Federal courts that would--

MR. BARRINGER. We have 50 or more laboratories at the State level to try new approaches, and so we would see very ideally that the Federal government would provide resources to try pilot projects out.

MS. DEGETTE. Right. Resources is a great idea, and Mr. Wootton's idea is a great idea. I think there are other roles for the federal government, but I think that is what we have to sort out.

I wanted to ask you, Mr. Barringer, you talked about the systemic mistakes. And actually, maybe someone else has an idea on this, too. I didn't hear anybody today talk about the fact that of medical malpractice by doctors, 5 percent of the healthcare professionals are responsible for 54 percent of malpractice claims paid. And it has always been my view that if we could, as well as many of these other excellent ideas, if we could target that 5 percent and figure out ways to improve performance for them that might help reduce medical malpractice.

MR. BARRINGER. We would say that that statistic is somewhat misleading, because it does not take into account the particular riskiness of certain specialties that are more often targeted for litigation. That is particularly the case because of what we know about the fact that malpractice claims are not a good indicator of quality among the physician population. But we would also see, in conjunction with a move towards a non-punitive administrative compensation structure at the State level, that it would be entirely appropriate to look for ways to beef up the regulation of the medical profession through enhanced, perhaps, standards, oversight, or some work in reform of the State medical boards, which is the hammer which comes down on the physicians.

MS. DEGETTE. So is what you are saying is that you think there is actually much more widespread medical malpractice among doctors than just 5 percent?

DR. MELLO. If I may jump in, the tricky thing--

MS. DEGETTE. Well, wait a minute. Let him answer, and then I will let you answer, Dr. Mello.

DR. MELLO. Okay.

MR. BARRINGER. The point that I am making is that we know, and I believe the statistic is from Public Citizen about the 5 percent of doctors leading to 50 percent or more of awards, and what we have consistently pointed to, with respect to that statistic, is that it does not account for the riskiness of particular specialties, which are subject more often to litigation. We don't know the answer. We know that there are vastly more injuries than are compensated.

MS. DEGETTE. Dr. Mello, would you like to add in?

DR. MELLO. Yes. The tricky thing about that statistic is that it is not the same 5 percent every year. It is a different 5 percent. So what that statistic tells you is that a small number of awards account for a large share of the costs, not that a small number of doctors account for a large share of the injuries, and certainly not that it is the same doctors from year to year who are injuring patients.

MS. DEGETTE. So you disagree with the study by the National Practitioner Database?

DR. MELLO. No, the data are accurate, but the interpretation that is often given of those data is that it is a small number of bad apples who are out there injuring patients year after year does not reflect what the data tell us.

MS. DEGETTE. Mr. Wootton wants to answer.

MR. WOOTTON. Yes. Actually, I have no idea what this data is or what it means or how to interpret it, but human nature is that there usually is a small number of people in any given population that have the greatest contribution to the cost, in any system. The beauty of what we are suggesting, and there are some differences between our proposals, is if you have a low cost of making a claim, if it is easy to come in, if you don't need to hire a lawyer, and I am not discouraging, in any way, the need for a lawyer, but if you don't need to hire a lawyer, you can come in and say, "Look, I think the standard of care has been breached here, and I have been injured." The ability to do that is going to drive up the standard of care and expose the doctors, if they are repeat offenders as opposed to just happened to be in the group that year, that they will expose the doctors who really have a problem, and you will have enough data points, by the way, to do experience rating of their malpractice insurance.

MS. DEGETTE. I just have one last question, and I would ask unanimous consent, and that is do any of you disagree that, as part of Congress's overall assessment of this, we need to look at malpractice pricing, practices, and risk pools?

DR. MELLO. Well, I have looked at this a little bit, and I haven't been able to find any data that would lead me to believe that overpricing of products has gone on during this latest malpractice crisis. I think that to the extent that companies have contributed to the problem, it was in under pricing products during favorable markets in the late 1980s.

MS. DEGETTE. All right. Mr. Chairman, it would really help if Dr. Mello would be willing to supplement her responses today to give us some of their data or the sources for that. That would be great.

DR. MELLO. I would be happy to, and I do have a report.

MS. DEGETTE. Thank you very much.

MR. BARRINGER. I would just have one additional point, if I may, to add, and that is that, based on our review--

MR. DEAL. Wait just one second.

I am going to hopefully go to a second round here, if everybody is agreeable to that and we would be able to come back, but let us let the members who are here participate before we get to a second round of that. We will hopefully remember where we were in that discussion.

Mr. Shimkus.

MR. SHIMKUS. Thank you, Mr. Chairman.

We are participating, and Dr. Burgess is jumping out of his seat and twisting, and I almost gave him my time just to hear his line of questioning, because I mean, just like many of you, he has real-world expertise in this area. And I am not going to let him do that, so it is good. Again, I think this has been a wonderful committee, and you have all been pretty forthright on the issue.

I also understand. I basically saw all of the names and scribbled notes, and your association has got a couple of universities. We have got a couple of law firms and some interest groups. And it is always interesting to see who funds these interest groups, because that does tell you. I mean, just like our opponents look at who contributes to us, and we get attacked for, "Okay, well, you must be that group or you must be supported by these folks." I think a good investigation of that would tell you some interesting stories about who is representing who.

Having said that, I want to welcome Ms. Niro from Illinois, my home State, although I am a downstater, and it is pretty far away from Chicago, Illinois. And so you followed what is going on, the medical liability issue. At least we have plateaued, because legislation passed at the State, and I don't know if you confirm that our Supreme Court has had a major pushing of folks to the table to at least pass some legislation

that we think hopefully would be helpful. I think the jury, if I can use that term, based upon discussions, is still out on how long that would be successful. But Madison County has slipped down the list of concerned jurisdictions. Cooke County has catapulted to the top. Do you know why?

MS. NIRO. Well, actually, I was President of the State Bar between two major tort reform legislatures, and in earnest, I decided to look into how we could work with the Illinois Medical Society to come up with a solution, just as you good folks are trying today. I thought that the most helpful thing to do would be to actually do an empirical study to find out how bad this problem is. Every day I listen to the radio, they are talking about malpractice insurance.

MR. SHIMKUS. Ma'am, I only have 2 minutes, and I really have got a whole bunch more.

MS. NIRO. Let me tell you what our study showed. It showed that from 1994 through 2004 there were no upward trends in filings per 100 treating physicians in Cooke County. There was a modest increase in malpractice case filings between 1996 and 2004, but if you adjust for the growth in the number of physicians, there was no evidence of increase. The filings between--

MR. SHIMKUS. Let me stop you there. And you can submit that. But this year, there has been an exponential increase in premiums.

MS. NIRO. Yes.

MR. SHIMKUS. There has been a loss of doctors.

MS. NIRO. Yes, there has.

MR. SHIMKUS. And so I really want to get Mr. O'Connell, because I tell you, I am conservative Republican, but I adored Senator Moynihan, a straight-shooter, told you what he thought was right, whether you liked it or not, Social Security issues. He is right on reform. But Ms. Niro and Ms. Doroshow are continuing to support the status quo. And your testimony says it doesn't work. What issues do you have with their testimony?

MR. O'CONNELL. I didn't hear a word about the fact that it takes 5 and 6 years to settle these claims. Anybody who wants to defend the status quo, as I tried to indicate in my testimony, has got to defend the system that takes 5 and 6 years. Anybody who wants to defend the present system has got to defend spending 54 or 55 percent of the dollars that are spent on administrative and legal fees rather than paying patients.

MR. SHIMKUS. And if I may, that is consistent with Dr. Mello's report. And no one from your left disagrees with that, am I correct?

My time is out, but I would like you to finish, Mr. O'Connell. Do you have anything additional to add to that?

MR. O'CONNELL. Just that I think Dr. Mello got it right. Those are the two issues, and we have got to find the means of getting payment faster to people who really need it. You can talk all you want about ADR. You can talk all you want about mediation. We have had those in place for a long time. They haven't affected what Dr. Mello found, and they haven't affected what I am doing in my research. I don't find any lessening of the transaction costs or the timing overall, based on the amount of ADR, mediation, or other alternate dispute resolutions that we have. The system marches on, as Dr. Mello demonstrates, irrespective of these.

MR. SHIMKUS. And Mr. Chairman, I will just end by saying the Federal government is a big player in healthcare in this country, and as the cost of healthcare goes up, our costs of providing Medicare and Medicaid continue to escalate. And it is literally so much of the buying power in healthcare as a whole because of that money moving into litigation and the court system, and that is not in the healthcare system. We, as taxpayers, are being harmed by that, too, because it distorts the costs.

And I really do appreciate all of your testimony, and I yield back, Mr. Chairman.

MR. DEAL. Mr. Pallone is recognized.

MR. PALLONE. Thank you, Mr. Chairman.

I just wanted Ms. Niro and Ms. Doroshow to respond to Ms. DeGette's earlier question about the malpractice insurance pricing practices. I know you didn't get a chance, so if you could do that, and then I am going to ask some questions.

MS. NIRO. Well, I would like to also, if I may, just say that the status quo that I would be suggesting needs to be preserved as simply the constitutional right of citizens to have their Seventh Amendment protections remain. I think there is great room for innovation in how to deal with healthcare dispute resolution.

In response to the questions that we have before us today, I would just say that justice isn't easy. Systems aren't easy, and we don't do these things because they are easy. We can't find justice the easy way and the least expensive way. What we have to do is what is right and what is consistent with everyone's rights. If you would repeat her question, I would appreciate it.

MR. PALLONE. Well, why don't I yield to her and let her repeat it?

MS. DEGETTE. I saw you were raising your hand so eagerly. The question was do you think that Congress's oversight on this should be on medical malpractice insurance pricing practices?

MS. NIRO. As I was trying to explain before, there is absolutely no rational basis in Illinois based on what we have seen in lawsuits for

doctors to be paying increased insurance premiums. The statistics simply do not bear that out. In Madison, St. Claire County alone, in 12 years, we only found 11 jury verdicts that favor the plaintiff. There were only verdicts that exceeded $1 million, and one was reversed on appeal. Nevertheless, the insurance premiums asked by these doctors are escalating dramatically. If this committee does not look seriously into the irrationally increased expenses for insurance, I don't think that you will be able to put a solution in place that will actually have a positive impact on the situation.

MR. PALLONE. And I would say, as I said in my opening statement, that that is part of the problem here, because if you don't address that, and I think that is true for the Senate Democrats that keep being accused of holding up H.R. 5 that allow them just to really believe that the insurance premiums have to be addressed directly and that the cap in the tort reform isn't going to solve the problem.

Ms. Doroshow, quickly, because I want to ask you another question.

MS. DOROSHOW. Okay. Well, just briefly on the insurance issue, there are two important points to remember. One is the Council on Independent Insurance Agents, which monitors insurance premiums for doctors as all lines of insurance, has found that in the last 6 months, the average increase for doctors has been zero percent. In other words, rates are basically stabilizing now everywhere in the country. The reason is because we are in the part of the cycle. This is a very cyclical phenomenon. Yes, there was a great deal of under pricing the premiums in the 1990s. They all shot up everywhere in the country, irrespective of tort law. There are many management and underlying issues that were responsible for that, but they have now stabilized. So I think it is one reason why some of the pressure may have been alleviated on the need to deal with the insurance premium crisis that had been going on in the last 5 years.

Secondly, there is something Congress can do, which is to repeal the anti-trust exemption, which the insurance industry currently enjoys that no other industry other than Major League Baseball has in this country, and that has allowed prices to go up.

MR. PALLONE. All right. Now let me just ask you about these health courts, the problem of eliminating a jury is of great concern to me. In other words, this idea of moving legal cases outside the court system, which not only eliminates an injured patient's right to a jury, but subjects the injured patient to a single judge. And at least in a jury system, you have a number of decision makers that balance each other out. So based on your research and studies of jury verdicts, have you found that jury verdicts track the conclusions of objective medical experts? I mean, the

concern seems to be that the juries don't know what they are doing. And I don't think that is true.

MS. DOROSHOW. Right. Actually all empirical research on juries has found the opposite. They actually have been doing studies on juries' behavior for 30 years or more. There is a new book on this. They have excessively examined juries since the 1980s. They find that juries are consistent, conservative. Basically, if anything, they rule against the plaintiff more often than not. I think other statistics bear that out as well. But the main thing is that they are absolutely competent to handle any kind of complex case, particularly a medical malpractice case where you really have to delve into the life circumstances of an individual. These kinds of fault determinations are quintessential jury functions. They are competent to do it. They have always been competent to do it. If you ask judges who are the ones day-to-day in the courtroom with juries observing how they operate, with almost no exception, they believe strongly in the jury system and the ability of juries to handle medical malpractice or complex cases. The Dallas Morning News reported on a year 2000 survey of every Federal judge in the country as well as judges in Texas, and judges were in universal agreement that juries perform extremely well in complex cases and would, in fact, want juries to handle their own case if they were injured. There is absolutely no evidence at all that juries can't handle these cases.

MR. PALLONE. Thank you.

MR. DEAL. Dr. Burgess.

MR. BURGESS. Thank you, Mr. Chairman.

Just as an editorial comment, I can't wait for the day where across the hall in the Judiciary Committee we have a panel of seven doctors tell us how to reform the legal system.

On the issue of cost, and I am aware of the study from back in the early 1990s that said it was only 1 percent of the cost of the healthcare system, but you know that is not correct. I mean, I learned it in my early career as a resident that part of your function was to treat the chart, and defensive medicine is a true cost that the Federal government, since we pay 50 cents out of every healthcare dollar that is spent in this country, does bear a significant part of that.

But more importantly, that is the loss. And during the worst of the medical liability crisis in Texas, in the spring of 2003, we almost eliminated the specialty of maternal fetal medicine, and these were individuals who had been trained at State institutions. Their education had been subsidized by the State. But because they could not get insurance, they were leaving the State and not practicing the highest of high-risk obstetrics. And the community suffered as a result. We lost a neurosurgeon from our trauma system at Methodist Hospital and nearly

ground our trauma system to a halt. So these are very real costs that are paid for by society. They may not be reflected in a study that looks at the dollars, but they certainly are real costs that society bears.

Before I accidentally use up all of my time with talking, I do want to ask Dr. Mello, because I was, unfortunately, called out of the room when you gave your testimony. And if I missed this, I do want to know the answer. From your work, if there was one lever of government that we could pull, whether it be at the State or Federal level, what would be your recommendation to have the greatest improvement, the greatest bang for the buck, on our medical justice system?

DR. MELLO. Well, I think we have to try experimentation with some of our recent reforms, like health courts. I would suggest that that be facilitated by action at the Federal and State levels jointly. It should start small. There is a lot of suspicion and distrust about these kinds of reforms, and the way we build a case for something in academia is to gather evidence and data, and that is what we should do.

MR. BURGESS. Well, now we have gathered some evidence in Texas since 2003 on caps. And I will admit to you, 10 years ago, caps wouldn't have been my first choice for a solution, but it has made a believer out of me because of the fact that the year I ran for Congress in 2002, we had gone from 17 to 2 liability insurers in my State. You don't get much competition for rates when you have only got two insurers left, and one was packing his bags. Since we passed the medical liability caps in 2003, we now have 14 insurers, and we are getting better prices for medical liability insurance as a result. Texas Medical Liability Trust, my old insurer of record, has come down 22 percent since I started in Congress since that bill was passed back in Texas.

Let me ask a question, if I could, of Ms. Niro and Mr. O'Connell, because I am intrigued by both of your testimonies. Are either of you familiar with what is called the National Practitioner Databank?

MR. O'CONNELL. Yes.

MS. NIRO. Yes.

MR. BURGESS. How would a physician's reportage to the National Practitioner Databank be affected, or how is it affected under the current alternative dispute resolution system that Ms. Niro described? And Mr. O'Connell, what would you see if a system that you described, the voluntary system that you described, were to be enacted? How is the reportage of a claim against a physician going to be handled?

MR. O'CONNELL. Shall I go first?

MR. BURGESS. Either one.

MS. NIRO. Either one.

MR. O'CONNELL. Let me say that one could include in the bill that there be a recognition that the early offer is the main pursuit to a statute

encouraging the early offer, and therefore the settlement should not count in the databank or should be accompanied by an asterisk in the databank, indicating that the settlement was encouraged by the Government under a statute encouraging it. That would be one solution.

MR. BURGESS. Ms. Niro, do you have any thoughts on that?

MS. NIRO. I actually agree that it is one of the biggest impediments in getting healthcare providers to participate in alternative dispute resolutions, because they don't want dollars paid in malpractice liability to show up. That is one of the rating factors on hospitals. Doctors want to defend their fine reputation, their clean record, and so it disincentivizes any use of alternative dispute resolution. If the committee could suggest reforms so that reporting could be broader than just gross dollars paid in liability and identify those which were cooperative settlements, which were by alternative means where no finding of liability exists.

MR. BURGESS. Let me just reclaim my time. And Mr. Wootton, you can see why I would be very nervous about what you described. And can I ask our representative from the Joint Commission of Accreditation of Healthcare Organizations, how would your body look at this type of thing if there were an asterisk or, as Mr. O'Connell has suggested, a statement that this settlement occurred pursuant to a recommended rapid settlement offer that was made because of Federal statute?

MS. VANAMRINGE. Well, I think we have a significant problem that exists today with the information in the National Practitioner Databank because it lumps everything together. It is incomplete, and therefore very skewed data. So what you want is really to overhaul some type of central repository of information, so it is very clear when a settlement or when a disciplinary action is in there, whether or not there truly was a standard of care that was actually violated or whether this was a settlement made under other circumstances so that people would understand the type of information to make decisions based upon it. Certainly, they would look at information in which a standard of care was violated very differently than if there was not one violated and there was no evidence that it was violated.

MR. BURGESS. Mr. Chairman, just before I yield back, Mr. Wootton, I do feel obligated to tell you that, from my old profession, you would likely encounter a significant amount of pushback through the concept that you described today, and this is the very reason why, because--

MR. WOOTTON. Are you talking about the National Medical Data, sir?

MR. BURGESS. The repository for national medical data.

MR. WOOTTON. Well, no, that would be completely stripped of any identification of the doctor. It would really just be having access to the

facts in the electronic medical record: no identification of the doctor, no identification of the individual. I think there are other puzzles.

MR. BURGESS. And just quickly, I think the most important reform is the source of the standard of care. I think all of these things get handled better if people trusted that the standard of care that was at work here was in fact the valid standard of care. I think that is where a lot of the corruption of all of these issues begins.

MR. DEAL. Ms. Capps.

MS. CAPPS. Thank you, Mr. Chairman.

I want to give equal time to Ms. Doroshow. Both you and Ms. Niro were labeled as favoring the status quo by our Chairman and another colleague. And Ms. Niro, you weren't given a chance to respond. Could you briefly explain whether or not that is a fair labeling? But that is not the substance of my questions, so if you could, be brief.

MS. DOROSHOW. Well, I do think that there is an assumption being made here that the system is in a terrible crisis, and I don't believe it is. I think that the New England Journal of Medicine articles, both together, showed that the system is working, actually, pretty well. Now as I said, if there are proposals to encourage alternative dispute resolution that can be done to ensure that it is voluntary and the right to jury trial is preserved--

MS. CAPPS. I entered that, because I actually think you are also confusing apples and oranges. A lot of doctors pay really high premiums. That is part of what is being considered, I think, the status quo that both of you are favoring, and that is why I want the record to show where we should be focusing some of our direction in a different way.

MS. DOROSHOW. Right. The issue of insurance premiums is something that can be solved very clearly by stronger oversight regulation of the insurance industries practices.

MS. CAPPS. Thank you. That is, I think, an important statement to be in the record. And I think that should be the subject of a hearing. And I would hope that all of you look compassionately at that topic. Since the medical court is sort of the model that is being promoted today, Ms. Niro, I wanted us to understand it, because the American Bar Association, and it is a big organization, is very skeptical about it, and I want you to be able to tell us, for example, what it would be like to have a compensation schedule. I am going to give you three examples and you can do all of them or take your pick. For example, I am not an attorney, but I could understand that if you lose a finger, it might depend on whether you are a pianist by profession or a filing clerk. It would be not a very good thing to lose four either, but what would the schedule be like and how would that be taken into account? Also, I am really

concerned once we do move away from whatever regulation we have now, how would the medical court be held accountable? And then finally, a lot of the evidence for supporting it seems to come from European countries where it is successful but where they have a vastly different delivery of care, universal healthcare, which we don't have, would that color any of those?

MS. NIRO. Well, I think whenever a schedule of damages is contemplated, the possibility of not matching the unique circumstances of an individual's condition exists, as you rightly suggest. But also, the surgeon's use of his right hand is not equivalent to my 80-year-old mother's similar problem with her hand. So scheduling things without a unique and specific approach to an individual may lead to very illogical situations, as would leaving out any compensation for pain and suffering. If a woman has, as has occurred, the wrong breast surgically removed, and she has no economic damage under these policies, she would get nothing.

MS. CAPPS. I am interrupting you now, but as this was being presented, I was thinking this. How about little kids?

MS. NIRO. They have no economic damages, nor do most elderly, nor do the underemployed, nor do the unemployed. That is disparate treatment, under the law, unless we find some way to compensate them fairly. With regard to the analogy of the Scandinavian or European countries, you are absolutely right. They have other systems in place that our tort system currently needs to provide, like their childcare, their job trainings, their federalized healthcare delivery system.

MS. CAPPS. I will leave it at that.

Thank you.

MR. DEAL. All right.

MS. CAPPS. Although I can tell that there is room for more discussion on this topic, which is fact that it is a good hearing.

MR. DEAL. All right. I think we are going to go to a second round of questions here.

Oh, I am sorry. Mr. Ferguson is here.

MR. FERGUSON. I am sorry, Mr. Chairman. I have been jumping in and out, but I appreciate the chance to do my first round of questions.

I did just miss some of the testimony, but Ms. Doroshow, thank you for being here. Thank all of our panelists for being here. I didn't hear your back-and-forth and your comment myself, but I am told by staff the gist of it. I just wondered if you might tell me again. Did you say that essentially the status quo is okay with regard to the current system or that there are not significant problems with the current medical liability?

MS. DOROSHOW. Well, there were two different issues presented: one with regard to medical malpractice premiums for doctors.

Absolutely, that is a situation that needs far greater oversight and regulation of the insurance industry to solve that problem. The States that have done that have gotten rates under control and actually did not experience this most recent hard market crisis. So we would certainly encourage that sort of thing and for Congress to repeal the anti-trust exemption that currently exists for the insurance industry. It has been percolating for years here and doesn't really seem to get anywhere, but I think that if that were removed, it would relieve tremendous pressure on rates during a hard market. You would really see rates stabilize, I think. So with regard to premiums, absolutely something needs to be done.

MR. FERGUSON. Would you characterize the current medical liability scene or landscape as a crisis?

MS. DOROSHOW. Well, I am looking most particularly at the most recent New England Journal of Medicine articles, the two that came out in May, one that Dr. Mello participated in and then there was a second one. Basically, her study has showed that people who are legitimately hurt, legitimate claims, are getting compensated, for the most part. Frivolous claims are not. Most of the costs of the system are going to resolve claims where there was medical error and injuries, legitimate claims. A very small percentage of cases are ending up in trial. Most of them were already, I believe, being handled properly by alterative dispute or negotiations. That is what their findings were. The second article in that very same issue was about how litigation can help ensure patient safety in hospitals and how that works, and so the implication there is certainly if you take away the threat of litigation, that is going to hurt patient safety initiatives in hospitals. So based on those two reports, there is certainly not a crisis, and the authors of those studies were pretty clear about that. There is an issue that Dr. Mello raised earlier about people not partaking of the system enough, not enough people who are injured legitimately are getting compensated. Yes, I think there is some problem there; however, I think that this is not a simple answer as to why people are not suing or going to court right now. I, myself, have had two instances in my family of medical malpractice. We would never have considered the notion of suing the family doctor in our family. That is why most people are not going to court, unless they really need it, unless they really need compensation. If a catastrophically injured child is involved, those cases aren't making their way into the court system, and they are getting compensated. The other problem is a lot of people don't know that if there has been a death as a result of a hospital stay, that negligence was involved. The hospitals are not coming forward with that information, and there is probably a lot of error happening that people are not even aware of.

MR. FERGUSON. Sure. My time is very short. I want to give Dr. Mello a chance to respond, but I am just reminded, when we are talking about this issue, when I hear someone suggest that it is not a crisis or not a big problem, as I would characterize it, and I think many people would, I am reminded of the early days of the Iraq War when all of our troops were rolling into Baghdad and Saddam Hussein's spokesman was out on TV saying, "There are no tanks in Iraq. There are no American soldiers in Iraq. Everything is just fine." And then 20 minutes later, he was being hauled off in chains or something. It just seems like it is a real disconnect from reality when we see it all around us, both anecdotally and the evidence that Dr. Mello was talking about, to suggest that this is not a crisis.

Dr. Mello, if you would like, would you just quickly respond to what has been referred to?

DR. MELLO. Maybe it would just be helpful to clarify that I think we are talking about two different things here. When people talk about a medical malpractice crisis, they are generally talking about an insurance crisis. What Ms. Doroshow has just been speaking about, and what my article speaks to, is the performance of the malpractice system. A poor performing malpractice system may create insurance problems or may not. So they are two different things, and I would be happy to speak to either one of them.

MR. FERGUSON. Well, I am going to have more time later, so I will yield back.

Thank you, Mr. Chairman.

MR. DEAL. Thank you.

Let me start off this second round by just making some personal observations.

There are some entrenched patterns and habits here that will have to be broken to make any changes work. First of all, I think there is the entrenched perception, at least, from the legal community, admitting to a more modest medical court system would cut the lawyers out. I don't envision that as being the case. Quite frankly, the legal profession, in terms of medical malpractice, is restricted to a very, very small number of lawyers. That was one of the things, as a lawyer practicing in a middle-sized small town, all of the doctors were always mad at the lawyers, and nobody in the local bar had ever sued them. The reason is it is a very specialized practice. I envision that if you go to a court system that is less contentious, perhaps would be one way of saying it, you may see more lawyers actually be able to help their clients in a legitimate malpractice case without having to refer them to the big high-dollar lawyers, because those lawyers would be all of the ones that could afford to underwrite the discovery that is necessary to produce a case that is

going to stand up in court. So I think that perception from the legal community is maybe not quite in keeping with what we are talking about.

But the one big thing that I see that we are going to have to deal with, and we may not be able to ever overcome it, is the idea of making an analogy to the workers' comp system. I think that that was made. That is a system in which fault is not the issue. Now in any system that we talk about of making the process less complicated, whether it be in medical court or otherwise, we are still inherently going to have the concept of fault, even though I believe, Mr. Barringer, you used the Scandinavian term of "avoidability" of consequences. One of the big problems that has always been, as I see it, in any system we would devise, being able to separate the natural consequences of what has happened to this individual from consequences that have either been exacerbated or new consequences that have been caused by the medical procedures or whatever has occurred to them. Where is the trigger that distinguishes where one stops and the other one starts? I would like to hear, and maybe, Mr. Barringer, a good place to start would be you, this "avoidability" concept. The medical community is probably not going to like that, because it expands the idea of potential cases. That is one of the things we are going to have to deal with this. A legitimate policy question we are going to have to deal with is are we willing to move to a system that will compensate more individuals, maybe at not the same level of compensation of those who are currently receiving verdicts, or are we going to stick with a system that only rewards those in the most egregious cases who have the financial resources and the attorneys who can stick it out through the whole process? But how do you think the medical community will view moving to this "avoidability" concept rather than the traditional liability concept?

MR. BARRINGER. Well, naturally, there is concern in the medical community and in the insurance community about a new standard of liability that could expand access to compensation. Nonetheless, we think there is understanding within the provider community about a new standard which would purport more with the goals of improving patient safety and enhancing quality in the system. We are calling for pilot projects to begin to test the applicability of this system and the way in which an avoidability standard might be operationalized at the State level. I would note that the best available research around this issue, conceptual though it is, suggests that an administrative compensation system could be implemented. This research looked at claims data in Colorado and Utah. But an administrative compensation system with an avoidability standard of liability and a compensation schedule could be

implemented at a cost comparable to that of the existing system while compensating far more patients.

I would like to make just a few points about the schedule of damages. We don't envision a one-size-fits-all schedule, and we haven't proposed a schedule. But what we do envision is a system that would be likely developed by experts, perhaps the Institute of Medicine, that would take account of patient circumstances and severity of injury and creating some sort of grid or structure or matrix to encourage uniformity such that similarly situated claimants received similar amounts. The whole idea of the notion of a schedule is to enhance horizontal equity in the system, if you will.

Just to get to the point about a pianist versus a filing clerk who lost a finger, the schedule of damages that we envision is for non-economic awards, or pain and suffering. So if you had a concert pianist who lost a finger, naturally economic damages would cover the losses to that musician. I as a person who actually personally enjoys playing the piano but don't make much of a living playing the piano wouldn't get much from the system except pursuant to the schedule, and perhaps there would be some provision for taking that into account.

I would also note that little children do have access to economic damages in the current system.

The final two things I just want to say is that the comparisons that have been made to the European systems and which we are basing some of this system, it is true, they do have universal coverage and a range of other benefits that they provide to folks, but in terms of the potential for reduced adversarialism, expedited compensation, and improving the relationship between individual patients and their physicians, we think there are a lot of lessons to learn from particularly the Scandinavian system.

Finally, I would note that the proposal that we have put forth is one that is evolving, and we are actually grateful for all input that we can get from stakeholders around, because we think that that is the way to make the most robust proposal we possibly can.

MR. DEAL. All right. Thank you.

I am going to ask Mr. Ferguson to assume the chair, and I want to tell you again how much I appreciate all of your testimony. Hopefully, we will be able to continue this dialogue in the future. I have something on the floor that I need to get to, and I am going to ask Mr. Ferguson to take the chair.

Ms. DeGette, you are recognized for questions.

MS. DEGETTE. Thank you, Mr. Chairman.

Ms. Niro, I assume that the ABA's objection to the health court system is not that it would take resources away from lawyers, but rather that it would remove the right to a jury trial, correct?

MS. NIRO. Absolutely.

MS. DEGETTE. And I wanted to ask both you and Ms. Doroshow, there are a lot of alternative proposals that have been presented. Mr. Wootton presented the idea of the national medical data center. Would either of you object to that kind of a concept of a national data collection system with privacy and liability protections so we could figure out what is going on here and find ways to improve service for patients?

MS. DOROSHOW. Well, we certainly believe that disclosure of information--

MS. DEGETTE. I am sorry. I don't have very much time. Do you object to that kind of a--

MS. DOROSHOW. Well, the answer is, when you are infringing on the patients' rights to be able to use an admission of negligence in court, so if--

MS. DEGETTE. Well, that is not what he is doing. He is talking about data collection at a national center. Do you have objection to that?

MS. DOROSHOW. No.

MS. DEGETTE. Ms. Niro, do you?

MS. NIRO. No.

MS. DEGETTE. Okay. I am sure neither one of you would object to enhancing efforts at early dispute resolution, so long as they didn't remove fundamental rights like the right to a jury trial, correct? Ms. Niro?

MS. NIRO. Yes.

MS. DEGETTE. Ms. Doroshow?

MS. DOROSHOW. Right, and it didn't exert undue pressure on the victims themselves.

MS. DEGETTE. And you don't object to programs like the program that I was talking about in my opening statement, which is being done in Colorado by our COPIC Insurance Company. I think Mr. Barringer talked about it, where we have efforts to get doctors to communicate with patients if there is an unintended injury, apologize, and try to rectify that at an early stage, so long as it doesn't remove rights to jury trial and other rights, correct?

MS. DOROSHOW. Well, the only thing we are concerned about is the negotiation period, which is laid out, and during the 6 months that I have seen in the Federal--

MS. DEGETTE. And you don't have objection to State efforts like that, do you, overall?

MS. DOROSHOW. Overall, but the devil is in the details, unfortunately.

MS. DEGETTE. Right. Ms. Niro?

MS. NIRO. May I declare that the ABA doesn't have a current policy pending? In my opinion, I think it is a positive thing.

MS. DEGETTE. I mean, what I am trying to point out is you two, at this end of the table, have been painted as people who don't think we should have any reforms or advances. But I don't think that is what I hear you saying. Is that right? Ms. Niro?

MS. NIRO. Thank you for clarifying that. I think we are all here for the purpose of trying to improve the delivery of healthcare and improve the fairness in which we are all treated.

MS. DEGETTE. You just don't want to remove the rights of patients to be compensated, right?

MS. NIRO. That is right.

MS. DEGETTE. Now, Ms. Doroshow, I want to ask you. A lot of people have been saying that caps on malpractice awards reduce malpractice premiums. That is kind of an assumption that a lot of people make. Are you familiar with data which would speak to that?

MS. DOROSHOW. No, there is a tremendous amount of data which contradicts that statement.

MS. DEGETTE. Would you please talk about some of it?

MS. DOROSHOW. Sure. Well, first of all, anecdotally, many States' rates are stabilizing all over the country because we are in a soft market period, whether or not caps were enacted. Rates shot up because we were in a certain part of the market. They have now stabilized. But in addition, many empirical studies, one done for our organization, found that there was actually a higher increase of rates in States that had caps than States that didn't. Economists have looked into this. University of Texas economists have looked into this. They have all reached the same conclusion: that there is a disconnect between caps and insurance rates.

MS. DEGETTE. Ms. Niro, you are nodding your head. Is that also--

MS. NIRO. I am in agreement with her statement.

MS. DEGETTE. Okay. The Kaiser Family Foundation, I don't know if anyone here if familiar with that, showed that the number of paid claims per thousand active physicians was unrelated to whether a State had caps. Does anyone know about that study? No? Okay.

DR. MELLO. I do.

MS. DEGETTE. Oh, Dr. Mello knows about it. Sorry.

DR. MELLO. I am aware of that study. I would just clarify that the argument has never been that caps affect nor that the malpractice crisis is driven by an increase in claims.

MS. DEGETTE. Well, I know that you are a well respected academic, and I respect your findings, and I know that is not your claim, but that is the claim that many in Congress have made as a rationale for why we should enact this legislation at a Federal level, but you, as an academic, don't know of any correlation between malpractice insurance rates and State caps?

DR. MELLO. Oh, now we are talking about something different, so I was just speaking a moment ago about the frequency of claiming.

MS. DEGETTE. Okay.

DR. MELLO. I had the privilege of spending the last year looking at the available evidence about the relationship between caps and premiums, including the stakeholder studies, like the ones that were just mentioned, and controlled academic studies. My conclusion is that there is a modest, but statistically significant association.

MS. DEGETTE. Thank you very much.

MR. FERGUSON. [Presiding.] Now I will continue the questioning.

Ms. Doroshow, I will give you another shot. I didn't mean to suggest that I was comparing anybody here to Saddam Hussein's spokesperson, and I don't know if anybody mistook that, but let me come back to you on another sort of related issue.

You had said that this health court system that had been talked about or suggested might tilt the playing field in favor of insurance companies that represent healthcare providers. But as a system that relies on independent experts to make qualified decisions on the negligence of a provider, might that not be more fair than a system where experts are simply hired folks who come in and who are paid to say whatever it is they say, depending on what side they are representing? Doesn't that system sort of tilt the playing field in favor of whoever can pay the most to hire the so-called best experts or most experts?

MS. DOROSHOW. Well, the thing that ensures fairness is that the decision maker is fair. In the health court model, you have got a specialized judge, who is, most logically, going to come from the healthcare industry or have a medical background. Already this is somebody that a patient is going to see as somewhat biased. Then heavily relying on medical experts coming from the healthcare industry, that is who is going to be making the decision as opposed to an unbiased judge or a jury. That is really the only way to ensure fairness in a situation like that. You have experts battling it out before jurors, but they make the decision and their job is to reach the most fair decision. When you remove that process, the process becomes biased.

MR. FERGUSON. Clearly, there is the potential for, if you are changing the decision makers, you are changing the folks who are deciding on the fairness, there is a risk there. But is there not a risk

currently? It seems difficult to defend the fairness if we are talking about simple fairness. It seems difficult to defend the status quo, in which case it is really whoever has got the deepest pockets, whoever can afford the best witnesses, because you are never going to call a witness unless they are going to say what you are paying them to say or an expert. You are never going to bring them in unless they say what you are paying them to say.

MS. DOROSHOW. Well, first of all, the cases that are getting to this point are ones where an attorney has already made a decision of taking the risk to take the case because they think it is a strong and valid case. That is what the contingency fee system does. It allows people access to attorneys, and it is a natural screening mechanism that kicks the worst cases out. And I am not the only one that said that. There are many conservative people that have said that as well. So you have already got a situation where it is generally a strong case, and they have a right to their experts. They have a right to consult with people who are going to advise their client--

MR. FERGUSON. I agree with all of that. My time is short. I agree with that. I am simply saying isn't there a great risk now? If there is a risk in changing to a different system, it seems to me it is tough to argue that. I don't know, maybe there is a greater risk or maybe there is less of a risk, but isn't there a tremendous risk in the status quo where we have got a bunch of experts that we parade through courtrooms who are paid to say what they are there to say? And it seems to me, there doesn't necessarily seem to be a great risk for a bias or a tilted playing field, to use your words, in terms of who can purchase the best experts.

I need to move on.

MS. DOROSHOW. Well, that is exactly what their function is: to evaluate experts and make decisions.

MR. FERGUSON. But if all they have access to is the best paid experts on one side and perhaps not on the other--

MS. DOROSHOW. They have experts, but that is their job.

MR. FERGUSON. I am just saying, it doesn't seem to me like it would be a level playing field in that case.

Ms. Niro, just a quick question on fees. Plaintiffs' attorneys charge, my understanding is, and I am not a lawyer, a contingency fee that amounts to 40 percent or more for an injured patient's compensation award. Plaintiffs' lawyers charge this standard contingency fee regardless of the specific details or the probability of winning or losing. However, and I want to reference Mr. O'Connell in a second, in Rule 1.15 of the ABA Model Rules of Professional Conduct, I have never read them, but this is what I am told, states that the contingency fees must be reasonable and should differ from case to case based on, among other

things, the likelihood of success or failure. Do you feel that plaintiffs should be protected from what some may say are unethical contingency fees? I reference an article that Mr. O'Connell wrote on this very topic in the Connecticut Insurance Law Journal. And if Mr. O'Connell would comment on this after, Ms. Niro, you have had a chance to respond to that question.

MS. NIRO. As I have said before, I am not a plaintiff lawyer. What I have done, however, is serve on the disciplinary board established by the Illinois Supreme Court that disciplines unethical behavior by lawyers, and we have never, to my knowledge, had to prosecute a plaintiff's injury lawyer for violating Rule 1.15, which is the reasonable fees requirement. If there are plaintiffs' lawyers that make one fee arrangement consistent in their practice, I do not know of them.

MR. FERGUSON. You do not know that the standard contingency fee is 40 percent in most cases?

MS. NIRO. No, I don't. As a matter of fact, that would seem outrageously high. If you had some plaintiffs' lawyers here, I think they would tell you that they lose cases to other lawyers who will manage the case for less money. What happens is the contingent fee is very relative to the class of the disbursements and the necessary preparation for trial. Most lawyers I am aware of have less than a third in agreements with clients.

MR. FERGUSON. Mr. O'Connell, can you comment on that? You wrote an article on this.

MR. O'CONNELL. That is not my experience. My experience is that the 33 and 1/3 and 40 percent is very standard, that, in addition, that figure is taken off the top, according to the contingency contracts that I have seen, namely, the lawyer takes the 33 1/3, and it is often 40 percent, certainly if there is going to be an appeal and increasing this 40-percent standard such that all of the expenses are borne by the client, if you see what I mean. You take the 40 percent off the top and all of the expenses then are left to the client to pay as well as receiving what is left once the 40 percent is taken off the top and the expenses of expert witnesses and exhibits are deducted. So we have to differ. My impression is that the situation is far from sanguine, that it is a very corrupt system. If there is a great deal of competition, for example, if you go to the yellow pages, which I have done and have research assistants do for years, you will never see any mention of competitive pricing by any lawyer advertising in the yellow pages, and the yellow pages are full of hundreds and hundreds of ads for personal injury lawyers. I challenge somebody to come in here and tell me one ad they have ever seen which says, "We will charge you less than a third."

MR. FERGUSON. Okay. I am way over my time.

Ms. Capps.

MS. CAPPS. Thank you. I think we are just getting into the thick of things. And Ms. Doroshow, I will let you respond some to Mr. O'Connell, but I also only have the 5 minutes, and I want to get to Ms. Niro talking about alternatives to going to court that would be maybe an alternative to the health court system. But for starters, my background is healthcare as a nurse, but I come off on medical malpractice often differently from the physicians with whom I have worked for a long time in my community. So in California, we have done tort reform for healthcare. Still, there is this myth, it is considered a myth, doctors that I know assume, and maybe the general public as well, that people go to trial and get huge settlements, disproportionate to reality and that suddenly the next day the doctor's malpractice insurance premium has to go up to take care of that. I heard you say something about the market is soft. Are we talking about the stock market regulating premiums?

MS. DOROSHOW. It is the insurance market, actually. It is a cyclical market, and a soft market.

MS. CAPPS. Who determines it?

MS. DOROSHOW. The companies and their rates, basically. The Council of Independent Agents and Brokers is the agency that monitors insurance rates around the country, and beginning in 2001 to 2005, rates shot up pretty significantly.

MS. CAPPS. What was the reason for it?

MS. DOROSHOW. Well, there had been a large number of years where the prices were under priced because they were making lots of money by investing the premiums.

MS. CAPPS. The insurance companies?

MS. DOROSHOW. Yes.

MS. CAPPS. No correlation to damages?

MS. DOROSHOW. Oh, no.

MS. CAPPS. And payments out?

MS. DOROSHOW. No, you never heard a word about it.

MS. CAPPS. For physicians?

MS. DOROSHOW. They were under pricing policies below inflation, basically, to physicians beginning in the late 1980s all through the 1990s since the last hard market, which was in the mid-1980s. It is very cyclical and it is a very peculiar kind of accounting and underwriting that they do.

MS. CAPPS. I am going to stop, because that is not the focus of this hearing, but Mr. Chairman, I would respectfully request that this subcommittee have a hearing on this topic and do it far more justice than we can do in 2 minutes.

MR. FERGUSON. You got it.

MS. CAPPS. Pardon?

MR. FERGUSON. I mean, I will talk to the Chairman about it.

MS. CAPPS. Well, I am assuming you are the Chairman.

I am being facetious.

This is about alternatives and the idea that Dr. Mello and others have proposed is a very interesting one. And I think our system is needing some help, however, I am a firm believer that we have a system of justice in this country that includes a trial by jury. However, Ms. Mello, you sort of teased at or hinted at, and I want you to use whatever little time I have left, to talk about other alternatives. And suggest some ways that we could assess and voluntarily allow alternatives to going to court. Mediation is very successful in resolving family disputes. And would you continue?

MS. DOROSHOW. Well, I think that, as Dr. Burgess suggested earlier, one of the greatest impediments right now is where the data is collected, and I think if there were ways to incentivize the healthcare profession to engage earlier in the process of open exchange of information, I think these currently available ADR methods would be even more efficient and demonstrate that they are very effective in the marketplace.

MS. CAPPS. Could you give very specific ways that we could assist in that that would be appropriate for Congress?

MS. DOROSHOW. Well, I think you could certainly do some influence on changing that data reporting system. I do think that if you are going to pilot any projects, that you look at the current projects that are using mediation currently, as is Rush Hospital in Chicago, which is a national model, and allow those programs to be tested in other areas of the country to see if the same positive results could be obtained.

MS. CAPPS. Dr. Mello, you are the academic about a lot of these things. Have these projects been studied?

DR. MELLO. Not in as systematic a way as we would like. Of course, controlled studies are difficult to do when you only have one site.

MS. CAPPS. Right. I understand. Do you think what you are proposing, does it have to be a sort of totally different structure?

DR. MELLO. No, it doesn't. The health courts model can incorporate any number of alternative dispute processes at the first level of dispute resolution, which is the interactions between the two private parties: the hospital or the doctor and the patient.

MS. CAPPS. I know I am out of time, but since this is our last round, could I ask just one more?

MR. FERGUSON. Sure.

MS. CAPPS. I'm interested in your model, but I also don't want to let go of the ability to go to trial by jury. Can they work together?

DR. MELLO. Well, what we are proposing is a sort of opt-in demonstration program so that patients who really believe that right is important can choose to go elsewhere for their healthcare besides the limited number of providers who are opting into our demonstration.

MS. CAPPS. But then do I understand this? If it became the system, it would be for everyone?

DR. MELLO. We would have multiple levels of appeal, and the final appeal would be to a court of law.

MS. CAPPS. Oh, I see. That really isn't the same as what Ms. Niro--

DR. MELLO. It is not a jury.

MS. CAPPS. So you would be fundamentally taking an injured patient's right to a trial by jury away from them?

DR. MELLO. I don't see it in quite those terms, but actually, they would be--

MS. CAPPS. Could you say yes or no to my question?

DR. MELLO. There would be no jury trial in this system for participants.

MS. CAPPS. Wow. That is major. This is a country built on trial by jury.

DR. MELLO. I appreciate that fully, as a lawyer, but I think in this case the system doesn't work in the interest of patients as it doesn't work in the interest of injured workers or injured vaccinees and many other areas where we have carved out.

MS. CAPPS. Well, I would certainly hope we could explore all kinds of alternatives before we take this drastic step. Thank you very much.

MR. FERGUSON. Well, thank you all for being here.

Oh, no. I am sorry. Mr. Shimkus is recognized for questions.

MR. SHIMKUS. Thank you, Mr. Chairman. Again, this is a great debate. I think the passion on all sides is because most people feel the system is not working. And before we passed liability reform in Illinois, which the jury is still out on. We don't know if doctors are still leaving but slowly. But I represent 40 counties in the State of Illinois. Springfield South is probably about 47 counties, so it is actually the seventh Supreme Court district. I think there are about 47 counties. There was no neurosurgeons in 47 counties in southern Illinois. Now we have a couple. And that is from Springfield, the central part of our State, to Paducah, Kentucky. No neurosurgeon. Probably close to one million people. That is the problem.

Now the question is, Ms. Niro, how many medical liability insurers are there in Illinois?

MS. NIRO. I can't answer that with any certainty from one day to the next.

MR. SHIMKUS. Yes. Two. One has 95 percent of the market. That is a co-op. It is owned by doctors. It is a not-for-profit. So one of the reforms is how do you get more insurers into the market? Would anyone disagree with that, if you believe in competition? If it is such a lucrative business, why wouldn't people be flocking, the insurers, to Illinois? So we have to have the doctors develop their own insurance pool just so they have coverage. And that is really part of my frustration. And even the doctors' cooperative insurance is pricing the doctors out of the business. So the people who are running the co-op say, "We can't afford you," doctors who own this insurance company. That is crazy.

Dr. Burgess talked about Texas. And we always get confused with economic damages, pain and suffering. They get lumped in together. And the public gets confused, because no one ever disputes full economic recovery. They really dispute, even today, about whether kids get economic recovery. Ms. Niro, you say no. Mr. Barringer, you say yes. Who is correct?

MR. O'CONNELL. Well, one issue is whether a child is economically productive. That is, if a child doesn't have a job and the child dies, there isn't any basis for claiming the child, except for the medical expenses incurred for the child, that the child has cost money to anyone. That is why--

MR. SHIMKUS. Mr. Barringer is getting excited, so please.

MR. BARRINGER. I am not.

MR. SHIMKUS. No, no. This is what we do this for. It is the method to get you guys interacting.

MR. BARRINGER. My understanding, and my statement was, to the extent that you had an injury and if there were future productive losses or economic damages that would have been foregone due to the injury, that there would be entitlement to economic damages. Someone correct me if I am wrong, but I thought that that was the case.

MR. SHIMKUS. And of course the mother. Are you calculating economic damages for a mother who is not employed?

MR. O'CONNELL. Well, there would be replacement costs. You would have to hire a homemaker and others. Those costs would be economic losses.

MR. SHIMKUS. And so the whole cap issue is not talking about pain and suffering. This is in addition to.

MR. O'CONNELL. That is right.

MR. SHIMKUS. And Dr. Burgess just came back, but in the debate on how you get more insurers back, Texas went from 2 to 14. And how did they do it? They capped the second portion of the pain and suffering.

I have got two questions I have got to ask. I have been asking others, but I want to make sure I ask. I don't understand, Mr. Wootton, this

statement in your testimony. "How will patients benefit from the adoption of an experience-rated administrative compensation system?" What do you mean? Explain that.

MR. WOOTTON. Yes. That could be at the heart of the health court idea, but it is certainly at the heart of my idea, and that is that if you have a low-cost claim like workers' comp, there have been findings that more workplace safety was generated by the workers' comp system, which is an experience-rated compensation, which means that if you are an employer and you have lots of claims against you as an employer, then you are going to pay a higher rate for your workers' comp and that that rating that costs you as an employer more means you have somebody in your employ who is going to go around and make your place safer. That generates more workplace safety than the very random tort system or, for that matter, OSHA. I hope somebody will sort of catch on to what is going on here that if you make it easy for people to come in and say, "I think I have been injured because of a departure from standard of care," an avoidability kind of situation, you are going to drive up the standard of care. I will say one thing I think that the status quo people have to answer is why is it that half of the adverse events that happen with drugs happen in hospitals to old people that are taking generic drugs and those cases never get in the court system. The answer is old people are not attractive plaintiffs. Lawyers take cases that fit their business model. They do not take cases because they are really trying to serve the public good. What we are talking about is a system that will in fact drive up the standard of care. So that is the distinction that I am trying to make by an experience-rated compensation system providing more incentive for patient safety.

MR. FERGUSON. Before we go to Dr. Burgess, Ms. DeGette has a quick point of clarification.

MS. DEGETTE. Thank you.

I think some of the non-lawyers here are confused about economic versus non-economic damages. Economic damages, for any plaintiff, are the damages where there is an economic loss. So what that would mainly be is out-of-pocket medical expenses that they might incur and some projected expenses, like if somebody was disabled and they needed home healthcare, something like that. Economic damages. It would also mean loss of wages for that individual, so for a year, if you were injured and lost your job due to medical malpractice and sued, then they would calculate your projected economic damages. For stay-at-home moms, for children, for senior citizens, what these witnesses are saying is because there are no wages to be lost, then there would be no wages computed in the economic damages. And I was actually talking to the Chairman about this earlier. For children, for future lost wages, most of

the time, that would be speculative, because those are young children that don't have that economic loss. So I think in some States, and I am sure some of my friends will correct me, you might be able to compute future wage loss for children based on parents or something like that. But that would not be included in economic damages. That would be non-economic damages that you are calling pain and suffering, but it is actually a much broader group. And the non-economic damages are the damages that the States put the caps on. So I hope that clarifies what those different types of damages are.

MR. SHIMKUS. And if I may, I appreciate that. I am not a lawyer, and I see heads shaking yes and no, so I think there is some frustration. But if the gentleman is correct, then why not develop a system by which you then can calculate non-economic damages? I know one of my State senators, a Democrat, a good friend of mine, Bill Hayne, who was involved with the legislation, brought this issue up all of the time. So I know it is a valid issue and a valid debate. I don't know if we are willing to sit at the table and address--

MS. DEGETTE. Right. Well, we actually do have a system right now in all 50 States that computes economic and non-economic damages, and that is called the tort system. But that doesn't mean we shouldn't look at some other innovative ways like the witnesses are discussing today to compensate. It is really not about what the damages are. It is how we can resolve cases much more quickly and efficiently.

MR. FERGUSON. Dr. Burgess.

MR. BURGESS. Thank you, Mr. Chairman.

Let me ask Mr. O'Connell again on this concept of economic and non-economic damages. The diagram that you proposed in your testimony, I believe, you were just talking about a voluntary system that would get rapid payment for what would be described as economic loss. Is that correct? Do I understand that correctly?

MR. O'CONNELL. It would be voluntary from the point of view of the defendant. The defendant would have the option of offering to pay economic loss within 180 days of the claim.

MR. BURGESS. What would be the objection to including non-economic damages under some parameters, whether it be a cap or some percentage of the total claim?

MR. O'CONNELL. What you are trying to do, sir, is incentivize a defendant to come forward and pay essential losses. Today, the defendant has the right to come forward and offer to pay both economic and non-economic damages within 180 days, or any other period, but I suggest, as I said in my submitted statement, that for either side to come forward early on the defendant's side to make a generous offer or the plaintiff's side to make an offer to settle encourages the other side to

become a participant. That is, if I, as a defendant, come forward to you very early on and make a generous offer of both medical expense and wage loss plus your pain and suffering, counsel is liable to say, "Why are they offering this much this early? Maybe they are hiding something back there. Who knows? But we are not going to take this early settlement." Similarly, if the plaintiff comes forward and says, "All I want is my economic loss," and the law entitles them to non-economic loss, the defendant will kind of say, "Well, why are we paying him that if that is all he wants? He must not be entitled to anything, or much less." So what I am trying to do is encourage the defendant to come forward and offer to pay economic loss in order to get that prompt payment of economic loss. So he has got that incentive to make the offer. The plaintiff now has the incentive to accept it, because he cannot sue for non-economic loss unless he has got a case for gross negligence provable by clear evidence. So I am trying to encourage--

MR. BURGESS. It is an enormously attractive concept. If there were a way to capture that spirit into legislation, would you envision that as a State issue or as a Federal issue?

MR. O'CONNELL. It could be enacted either way. There was a Federal bill introduced a few years ago by Senator McConnell of Kentucky and a few years before that Representative Gephardt introduced a bill applying this scheme for federally-funded healthcare recipients, Medicare and Medicaid. Neither of them passed, but I have drafted legislation, and legislation was drafted by the staff of those two legislators, so it is what I am suggesting to this committee.

MR. BURGESS. The concept of creating a savings for the Federal government, we do spend 50 cents out of every healthcare dollar that is spent in this country, also is enormously attractive to me, which is why I would like to think along the lines of a Federal solution, but I am concerned, since my own State has successfully tackled and passed legislation and passed to constitutional amendment, which has been enormously effective at keeping doctors and insurers in the State. Would this type of legislation be injurious to a State that has already dealt with the problem satisfactorily?

MR. O'CONNELL. No, I don't think so. You could draft a statute such that it doesn't displace what the State has already done. It might add an additional incentive. In other words, you now have a cap on pain and suffering. Under this scheme, the defendant could make the offer to them and a payment for pain and suffering as long as there was prompt payment for the economic loss, which would do away with the claim for non-economic loss, which already exists in Illinois, below the cap.

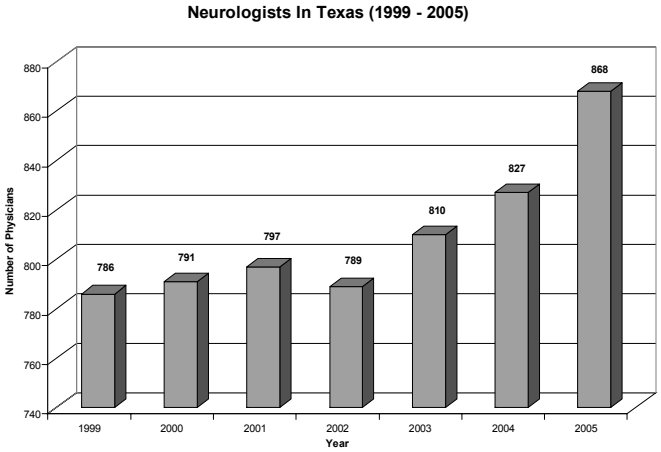
MR. BURGESS. Well, I thank you for your testimony and for everyone on the panel for their forbearance today.

Mr. Chairman, I would like to ask unanimous consent that I insert into the record data from Texas that deals with the number of neurologists in the State showing a gradual increase up until the year 2002 and then a dramatic decline. Following the passage of our medical cap, the number of neurologists has dramatically increased in the State. I think this study on the neurologists in the State just really is illustrative of the problem and how at least one State has solved that problem.

And with that, I will yield back.

MR. FERGUSON. Without objection, that will be included in the record.

[The information follows:]



Source: Texas Medical Board – May Reports

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MR. FERGUSON. Let me thank all of our witnesses for being here today. This is an extremely important issue, and we need to be thinking

outside the box. Your testimony has really helped us in that regard, and we really hope to continue to hear more from you in the future as we try to get our arms around this problem.

Thank you for being here today. We appreciate it.

We stand adjourned.

[Whereupon, at 1:14 p.m., the subcommittee was adjourned.]

RESPONSE FOR THE RECORD OF MICHELLE MELLO, J.D., PH.D., ASSOCIATE PROFESSOR OF HEALTH POLICY AND LAW, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HARVARD UNIVERSITY

Responses of Michelle Mello, JD, PhD to questions from The Honorable Diana DeGette:

1. In response to my question regarding the fact that five percent of health care professionals account for 54 percent of malpractice claims paid, you testified that it is not the same five percent of health care professionals causing malpractice injuries every year. The statistics I cited, and which you testified were accurate, included information from September 1, 1990 to September 30, 2002 in the National Practitioner Data Bank. Does this not show that over a long time period, twelve years, it was a small number of health care professionals who caused a disproportionally large share (54 percent) of malpractice injuries (as measured by amount paid in damages)?

The NPDB 2002 Annual Report (page 35) states:

> **A few physicians are responsible for a large proportion of malpractice payment dollars paid:** The one percent of physicians with the largest total payments in the NPDB were responsible for about 12 percent of all the money paid for physicians in malpractice judgments or settlements reported to the NPDB since its opening in 1990. The five percent of physicians with the largest total payments in the NPDB were responsible for just under a third of the total dollars paid for physicians over the period. Eleven percent of physicians were responsible for half of all malpractice dollars paid, or settlements from September 1, 1990 through March 31, 2003.

These data indicate that malpractice payments tend to be concentrated among a relatively small group of physicians. The most likely explanation for this is not that a small number of *physicians* are repeatedly sued, but that a small number of high-cost *claims* account for a large proportion of the expenses. It is highly unlikely that these high-cost claims involve the same physicians each year. I am not aware of any data that support such a notion.

Among the data in the NPDB report that suggest that high-cost claims, not repeatedly sued physicians, are responsible for the skewed distribution of claims costs are the following:

- The 1% of physicians with the highest total claims payments accounted for 12% of all payments (page 35).
- The differences between the mean and median claims payments in Table 10 of the NPDB Annual Report are large. When means are much higher than medians, it indicates that a distribution contains a small number of high values.
- About 84% of physicians have two or fewer NPDB reports, 97% have five or fewer reports, and 99.5% have 10 or fewer reports over the 1990-2002 period (page 34).

2. Do you agree or disagree that a small number of health care professionals cause a disproportionally large share of medical malpractice injuries? On what basis do you agree or disagree?

I disagree that there are any data available to support the proposition that a small number of health care professionals cause a large share of malpractice injuries. To my knowledge, no data are available to support or refute such a claim.

The NPDB data discussed above do not support this claim because, among other reasons, they relate to claims payments, not injuries. The correlation between injuries and claims payments is weak. The overwhelming proportion of medical injuries never become claims, and about half to two thirds of claims do not result in a payment. Therefore, we cannot infer anything about who is injured, or who causes injury, on the basis of data indicating which doctors have faced claims that resulted in payments.

3. Please describe any academic studies of which you are aware that support or refute the proposition that a small number of health care professionals cause a disproportionally large share of medical malpractice injuries.

Please see my response to question #2, above.

The following studies do not directly address the question, but establish the weak link between injury, claiming, and payment discussed above:

Localio AR, Lawthers AG, Brennan TA, et al. Relation between malpractice claims and adverse events due to negligence. Results of the Harvard Medical Practice Study III. N Engl J Med 1991;325(4):245-51.

- A key finding of this study is that only about 2% of medical injuries attributable to negligence become claims.

Studdert DM, Thomas EJ, Burstin HR, Zbar BI, Orav EJ, Brennan TA. Negligent care and malpractice claiming behavior in Utah and Colorado. Medical Care 2000;38(3):250-60.

- This study confirmed the 2% finding from the Harvard Medical Practice Study on a different sample of medical injuries.

Studdert DM, Mello MM, Gawande AA, et al. Claims, errors, and compensation payments in medical malpractice litigation. New England Journal of Medicine 2006;354(19):2024-33.

- Key findings of this study are that about 63% of claims involve medical errors and about 56% of all claims result in payment. Among claims that involve medical errors, about three quarters result in payment and a quarter do not. Among claims that do not involve errors, about one quarter result in payment and three quarters do not.

4. How do you interpret data reported by the group Public Citizen in January 2003 from the National Practitioner Data Bank, covering the period September 1, 1990 to September 30, 2002, that only eight percent of health care professionals who paid claims for medical malpractice injuries two or more times and 17 percent of those who paid five or more times have been disciplined by their state's medical board?

Most scholars of medical liability, and many in the medical community, agree that medical boards have not been aggressive in policing physician quality/competence problems. Their investigations and disciplinary actions tend to center on physician

misconduct (such as substance abuse) rather than physician competence. However, it would be a mistake to conclude that having two or more paid malpractice claims, or even five paid claims, should result in disciplinary action. As the Studdert et al. 2006 article referenced above shows, many claims are paid in the absence of evidence of negligence. A large number of paid claims against a physician might reasonably trigger scrutiny by a disciplinary board, but the question of whether those claims indicate a pattern of negligence is not answered by the mere existence of those payments.

5. Do you agree or disagree that very few health care professionals are ever disciplined by state medical boards? On what basis do you agree or disagree?

Please see my response to question #4.

6. Do you agree or disagree that very few of the health care professionals who commit multiple instances of medical malpractice are ever disciplined by state medical boards? On what basis do you agree or disagree?

Please see my response to question #4.

7. Other than health courts, and under our current system, what can policy makers do to better ensure that health care professionals who should be disciplined by state medical boards are so disciplined?

Two mechanisms that could be helpful are:

1. Ensuring that medical boards (and/or state departments of health) have well publicized mechanisms for patients and staff in hospitals and clinics to complain about perceived physician competence problems. As noted above, malpractice claims are a crude indicator of physician competence. Other countries, such as New Zealand, use a parallel complaints process to gather reports of competence problems and investigate them. The following articles may be of interest:

   Bismark M and Paterson RJ. No-fault compensation in New Zealand: harmonizing injury compensation, provider accountability, and patient safety. *Health Affairs* 2006;25(1): 278–283.

   Paterson RJ. The patients' complaints system in New Zealand, *Health Affairs* 2002;21(3):71–79.

2. Conducting formal audits of medical board activity.

8. You testified that there was no overpricing of medical malpractice insurance during the recent increase in premiums, beginning in 2001. What data and studies did you review to make this conclusion?

To my knowledge, no studies or data have established that overpricing occurred. One useful indicator is insurers' loss ratios, as reported by the National Association of Insurance Commissioners. These ratios compare the money collected in premiums to what was paid out (or incurred) in claims costs. These ratios were less than 1 for insurers in many markets until recently, meaning that what they charged was not adequate to cover their losses.

9. You also testified that medical malpractice insurances companies contributed to the dramatic increase in malpractice premiums by underpricing products in the late 1980s. Explain.

A good explanation of this issue is available in the paper by Bovbjerg and Bartow at http://medliabilitypa.org/research/report0603/. In brief, some insurance companies appear to have underestimated their claims liability during the favorable markets of the 1980s and 1990s. They competed strongly on price. They later found that they had a "tail" of liability on for which they had not adequately reserved funds. Malpractice claims have a long "tail" because patients may wait 2-3 years to file them and then the cases typically take 3 or more years to resolve. During this period, the insurer can only make an educated guess about what its liability will ultimately be. Some insurers guessed wrong; they did not charge enough to cover what they eventually had to pay. Some went out of business as a result, as the Bovbjerg and Bartow paper explains.

10. What would have occurred had medical malpractice insurance companies properly priced malpractice insurance products in the 1980s? For example, would there have been an increase in premiums beginning in 2001? If there would not have been such an increase, in this way did medical malpractice insurance pricing practices contribute to what the health care industry perceives as a medical malpractice insurance liability crisis?

Some insurers' loss ratios would have been more favorable heading into the 1990s. Because the most recent malpractice crisis had multiple causes (please see my response to question #11, below), I cannot conclude that later increases in insurance prices could have been prevented by earlier increases.

11. Do you or disagree that the dramatic increase in premiums for medical malpractice liability insurance is consistent with the historically cyclical nature of pricing for that industry? On what basis do you agree or disagree?

My views on this subject are available on pages 11-12 of the report at http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no8_primer.pdf. In brief, I believe that the "insurance cycle" contributed to the malpractice insurance crisis but was not the sole contributing factor.

12. You testified that there was a small but statistically significant relationship between caps on non-economic damage awards for medical malpractice injuries imposed by states and medical malpractice premiums. Explain. On what basis did you make this conclusion?

I reviewed a large literature on this subject in the process of preparing the following report:
http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no10_researchreport.pdf. The relevant studies, their findings, their limitations, and my overall conclusions are discussed in detail there. Among my findings were that many of the reports put out by political interest groups are unreliable on this subject; however, a small number of well-designed academic studies provide reliable evidence. The strongest studies on this topic, listed on page 12 of that report, find a modest effect of damages caps on premiums.

13. Please describe any academic studies of which you are aware that support or refute the proposition that caps on non-economic damage awards for medical malpractice injuries imposed by states do not have any effect on changes in medical malpractice premiums rates.

The relevant studies are summarized on pages 12 and 24-25 of the above-referenced report, http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no10_researchreport.pdf.

14. In June 2003, Weiss Ratings, Inc. found that states that with caps on non-economic damages for medical malpractice experienced a larger increase in malpractice premiums between 1991 and 2002 than states without such caps. It concluded that "[c]aps on non-economic damages have failed to prevent sharp increases in medical malpractice insurance premiums. . . ." Do you agree or disagree with these findings? On what basis?

The Weiss Ratings study is a descriptive analysis that simply compares the median premium in two groups of states without attempting to control for ways in which the groups of states may differ. This is not a scientifically defensible way to measure the effect of damages caps. Observed differences in premiums may be attributable to the presence or absence of a damages cap, but without controlling for other variables, we cannot know for sure.

The Weiss Ratings study findings are at odds with the findings of many well-controlled academic studies of damages caps (see response to question #13, above). The controlled studies should be given greater weight.

15. Please submit any reports, studies, and papers that you have prepared, alone or with others, regarding (a) the extent to which a small number of health care professionals cause a disproportionally large number of malpractice injuries; (b) the pricing of medical malpractice liability insurance; and, (c) the relationship, if any, between caps on non-economic damage awards for medical malpractice injuries imposed by states and changes in medical malpractice premiums rates.

All relevant work has been referenced above. Copies of works authored by me are appended. They are also publicly accessible at:

http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no8_primer.pdf

http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no10_researchreport.pdf

http://www.hsph.harvard.edu/faculty/MichelleMello.html ("Claims, Errors, and Compensation Payments in Medical Malpractice")

THE ROBERT WOOD JOHNSON FOUNDATION.

THE SYNTHESIS PROJECT
NEW INSIGHTS FROM RESEARCH RESULTS

RESEARCH SYNTHESIS REPORT NO. 8
JANUARY 2006

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Harvard School of Public Health

Understanding medical malpractice insurance: A primer

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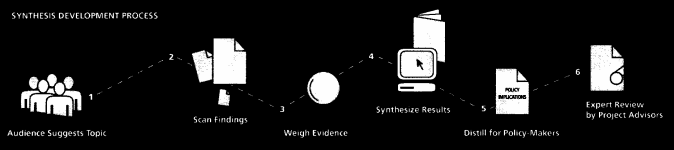
THE SYNTHESIS PROJECT (Synthesis) is an initiative of the Robert Wood Johnson Foundation to produce relevant, concise, and thought-provoking briefs and reports on today's important health policy issues. By synthesizing what is known, while weighing the strength of findings and exposing gaps in knowledge, Synthesis products give decision-makers reliable information and new insights to inform complex policy decisions. For more information about the Synthesis Project, visit the Synthesis Project's Web site at *www.policysynthesis.org*. For additional copies of Synthesis products, please go to the Project's Web site or send an e-mail request to *pubsrequest@rwjf.org*.



Introduction

As the policy debate over the medical malpractice insurance crisis continues, dueling claims about its causes and suggestions for policy solutions have highlighted the need for a better understanding of how medical malpractice insurance works, why premiums change and what can be done about it. This policy primer provides a basic description of these issues, focusing on the following questions:

- How does medical malpractice insurance work?
- How much do we spend on the medical malpractice system?
- What is a medical malpractice "crisis"?
- What causes malpractice crises?

This Primer is one in a series of reports addressing medical malpractice insurance issues. The series also includes a Research Synthesis and Policy Brief analyzing research evidence on how the medical malpractice crisis has affected health care delivery and the impact of state tort reforms.

How does medical malpractice insurance work?

Most health care providers need to buy professional liability insurance. Nearly all states require that physicians have liability insurance. Even in states that don't, physicians usually have to have insurance coverage in order to get privileges to see patients at a hospital. In some contexts, however, physicians can choose to "go bare." In Florida, for example, it is estimated that about five percent of physicians carry no liability coverage (17).

Physicians usually buy their insurance from a commercial company or a physician-owned mutual company, either individually or through a group practice. Hospitals and other health care facilities purchase their own insurance, and hospitals that directly employ physicians typically buy a policy that covers both the hospital and its medical staff. Physicians employed by the federal government don't buy insurance; if they are sued, the suit is brought against the federal government, which insures itself. Some state-employed physicians receive coverage from the state.

Premiums for malpractice insurance vary with the provider's degree of risk, but experience rating is not widely used. Insurers set premiums on a prospective basis based on: 1) their expected payouts for providers in a particular risk group; 2) the uncertainty surrounding this estimate; 3) their expected administrative expenses and future investment income; and 4) the profit rate they seek. They use information on past losses and expenses, combined with other information, to help them set rates.

Physician professional liability insurance does not work like auto insurance, which is generally experience rated. When a motorist has a claim, his insurance premiums go up. Physician malpractice premiums, by contrast, are usually priced according to the physician's specialty and geographic location only (some insurers also consider number of hours worked and types and setting of work within the specialty). Experiments with individual experience rating have not worked because physicians' claims experience is too variable over short time periods, making it difficult to produce an actuarially stable estimate of their risk.

For hospitals, some degree of experience rating occurs, but usually no more than 25 percent of the hospital's total premium is based on experience. Experience rating hospitals is more feasible than experience rating physicians because hospitals' claims experience is more stable over time. Hospital premiums also vary with hospital location (e.g., urban versus rural) and the clinical services offered (e.g., level of trauma care).

How does medical malpractice insurance work?

On average, it takes four to five years to resolve a claim from the date of an incident (23). In many states, plaintiffs can wait two or three years after discovery of an injury that allegedly resulted from malpractice to file a claim. This long tail means that insurers have a lot of uncertainty about what their liability ultimately will be. The difficulty of estimating liability for claims that have not yet been brought or resolved makes it hard for insurers to set premiums accurately.

Although recently a federal legislative issue, like most kinds of insurance, malpractice insurance is regulated primarily by the states. State insurance commissioners regulate rates to ensure that they are not excessive, inadequate or unfairly discriminatory. Variations in this state-specific regulation are one reason that premiums may go up (or down) in some states and not in others.

State departments of insurance follow one of six types of insurance regulation for medical liability insurance (Figure 1). Some make it harder than others for insurers to change their prices (23). Even within these six statutory approaches, there can be significant variation in the actual amount of oversight by the insurance commissioner. The commissioner may be relatively stringent or lenient in approving rate changes and more or less diligent in reviewing submitted materials.

Figure 1. State approaches to medical malpractice insurance regulation

	Insurance regulation approach	How it works
Most restrictive ▲	Prior approval	Insurers must file proposed rate changes with the state and obtain approval before the changes can be implemented (17 states in 2004).
	Modified prior approval	Requires prior state approval for rate revisions based on a change in the insurer's expense ratio.
	Flex rating	Requires prior approval only if the rates exceed a certain percentage above (and sometimes below) the previous rates.
	File and use	Requires that insurers notify the state of rates prior to their use, but does not require specific approval (23 states).
	Use and file	Requires that the state be notified after rate changes are implemented (9 states).
▼ **Least restrictive**	No file	Requires insurers to maintain records of information used in developing their rates, but does not require them to file notice of their rates with the state.

Source: Nordman et al., 2004. Source does not list the number of states using the modified prior approval, no file, or flex rating regime.

Rate regulation may have an important influence on insurance prices, but whether it raises or lowers them is not clear. In theory, regulation could keep prices higher or lower than they would be in an unregulated market. Prices could be higher if regulators set price floors in an effort to protect consumers against companies becoming insolvent because they dropped their rates too low and incurred liability they couldn't pay for. They could be lower if regulators refused to approve rate hikes in response to pressure from consumers to make insurance more affordable. Studies of auto insurance have provided support for both these hypotheses (6). No comparable studies of the professional liability insurance markets are available.

How does medical malpractice insurance work?

Several important recent shifts in the liability insurance market have affected how much health care providers pay for insurance and the amount of exposure they face.

Exit of some commercial carriers and advent of physician mutuals—Physician-owned-and-operated companies (mutuals) sprang up in the 1970s and 1980s to fill gaps left by the exit of commercial carriers. Mutuals may offer lower rates than commercials and give physicians greater control. Some mutuals with little underwriting expertise have faltered during hard markets, however,

Problems obtaining affordable reinsurance after September 11—Reinsurance, which covers losses above a specified threshold, helps organizations limit their exposure in a given year. Reinsurance has become more expensive for both self-insured hospitals and insurers during the most recent malpractice crisis. Along with other factors, the catastrophic losses that reinsurers suffered on September 11 made reinsurance more expensive. When reinsurance costs more, primary insurers' profits decline unless they pass along the increase to those they insure.

The growth of hospital self-insurance—Instead of opting for commercial insurance, many hospitals are forming captives (companies that are wholly owned by a single health care facility or hospital system) and other self-insurance arrangements in order to exert greater control over rates and leave a risk pool that includes higher-risk facilities. The downside is that self-insured hospitals tend to retain more risk, particularly if they have trouble finding affordable reinsurance. Also, prices in the commercial market may increase when lower-risk members leave the pool.

Shift from occurrence policies, which cover all incidents in the policy year regardless of when the claim is filed, to claims-made policies, which cover only claims filed in the policy year—Coverage is more meager under a claims-made policy; it leaves a long tail of exposure for incidents that haven't yet become claims. Most physicians purchase costly tail policies to cover these incidents, in addition to paying for a claims-made policy.

Increasing interest in hospitals buying insurance for doctors—By affiliating more closely with hospitals, some physicians have been able to find a stable, relatively low-cost source of insurance. This trend has widened the disparities between physicians who practice in large-group settings and those in small-group or solo practice settings, who are more vulnerable to fluctuations in overhead costs.

The growth of joint underwriting associations (JUAs) and patient compensation funds (PCFs)—JUAs are state-mandated insurers of last resort for physicians who cannot find insurance on the market. If the JUA's losses exceed the premiums it collects, other insurers in the state are required by law to contribute toward covering them. PCFs are state funds that operate like an excess-layer insurer—that is, if a judgment exceeds the physician's primary policy limit, the PCF pays the amount above the limit (or the amount between the limit and another statutorily-prescribed amount). They are funded by mandatory surcharges that physicians and hospitals pay on their primary-layer policies. These arrangements give primary insurers, physicians, and hospitals an extra cushion against large judgments, but impose additional costs that may be hard to bear in times of crisis.

Relatively poor returns on investment since 2000—Insurers invest much of the premiums they collect. Their portfolios tend to look fairly similar, typically consisting of about 80 percent bonds, 10 percent stock, 5 –10 percent cash and a smattering of other investments (23). These relatively conservative portfolios are required by law in most states. Even these portfolios, however, are vulnerable to swings in the equity and bond markets. Insurers, like other investors, have enjoyed less favorable rates of return on their investments since 2000. Median investment income among

insurers with 50 percent or more of their business in malpractice insurance dropped 52.7 percent from 2000 to 2002, from $4.5 million to $2.1 million, with investment yields dropping from 5.2 percent to 4.3 percent (23). This drop looks large, and is often cited as a leading reason for increases in insurance premiums. It is important, however, to remember that investment income is only a small part of total insurer income (23).

How much do we spend on the malpractice system?

Much has been said in the policy debate about the toll that malpractice litigation takes on the economy, but hard cost estimates are elusive. To calculate the total costs of the malpractice system one would need reliable estimates of both the direct and the indirect costs. The direct costs of malpractice litigation include payments made on claims (from which plaintiff's attorney fees and costs are taken), legal costs of defending claims and costs of underwriting and administering liability insurance. A recent estimate suggests that claims costs amounted to $4.4 billion in 2001, legal defense costs amounted to $1.4 billion and insurance administration amounted to $700 million. Thus, total direct costs were probably about $6.5 billion in 2001, or 0.46 percent of total health care spending (2). These and all estimates of the costs of the malpractice system, however, are back-of-the-envelope calculations; no hard cost figures are available.

Indirect costs arise when the liability system causes physicians to supply more health care services than they would in the absence of a liability threat. Services that are provided primarily or solely for the purposes of protecting physicians against malpractice liability, rather than the medical benefit of the patient, are referred to as defensive medicine. True defensive-medicine costs are properly counted as indirect costs of the malpractice system, but the costs of additional *appropriate* (i.e., medically indicated) services should not be included in that estimate.

There are no reliable estimates of the national costs of defensive medicine. Many analysts have attempted to estimate these costs; all have failed to do so reliably. All of the available measurement methodologies have serious shortcomings (10, 18). For example, some national estimates are based on the incremental cost increases associated with just two or three medical procedures or diagnoses. It is simply not possible to extrapolate so widely to other procedures, because some are more amenable to defensive medical practice than others. The Office of Technology Assessment conducted a comprehensive review of the evidence about defensive medicine costs in 1994 and concluded that none of available estimates were reliable (32). Much additional research has been conducted since then, but the conclusion remains the same.

Malpractice litigation costs and total health care spending are related, but not precisely. Because the cost of medical care for injured patients is a large component of malpractice awards, we should expect awards to rise along with increases in health care spending. Indeed, both average paid claims and per-capita health spending grew 52 percent in real terms from 1991 and 2003 (14 and spending data from Centers on Medicare and Medicaid Services). Malpractice awards also include other components, however, such as non-economic damages, so we should not expect them to precisely track health care spending.

What is a medical malpractice "crisis"?

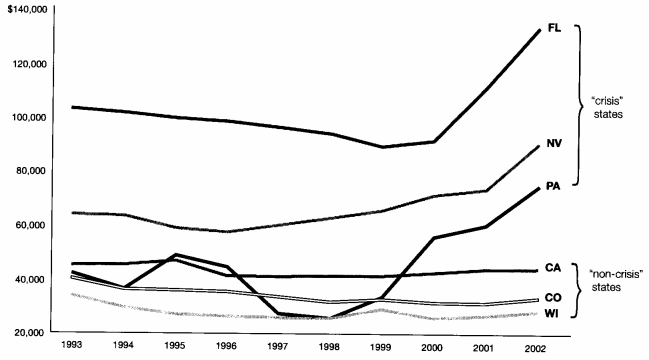
Stakeholder groups disagree about whether the current environment should be labeled a "crisis," but there is general agreement that malpractice insurance has become less affordable and available. A malpractice crisis is a period of volatility in the medical professional liability insurance market in which deterioration in insurance carriers' financial

What is a medical malpractice "crisis"?

ratios is followed by higher-than-historical increases in insurance premiums and/or decreased supply of insurance. The use of the word "crisis" is controversial because of the severity and urgency it connotes, but the term is widely used in the academic scholarship as well as policy debates. Further details about the current crisis period and previous crises are provided below.

When evaluating whether a state is experiencing a medical malpractice crisis, one should look at both absolute levels of premiums (Figure 2) and the amount of change from year to year. It is also important to juxtapose these costs with how generously providers are reimbursed in the state, as reimbursement affects providers' ability to meet rising insurance costs.

Figure 2. Average liability premiums for OBGYNs in select "crisis" and "non-crisis" states, 1993–2002



Source: weighted average premium (weighted by insurer market share and population) for a standard primary-layer policy for obstetrician-gynecologists, calculated from data reported in the *Medical Liability Monitor Annual Rate Survey* and in National Association of Insurance Commissioners' 2004 report by Nordman and Cernak. Where applicable, premiums also include mandatory surcharge to state patient compensation fund. All dollar values were adjusted to 2003 dollars using the GDP deflator. Pennsylvania, Florida and Nevada are "in crisis," and California, Colorado and Wisconsin are "currently OK" according to the American Medical Association.

Malpractice crises are state-specific phenomena. There are several reasons crises tend to affect states rather than regions or the entire country. First of all, sociodemographic variations across states make for very different tort environments in terms of litigiousness and average award size. In addition, the rules governing malpractice litigation vary across states, malpractice insurance is regulated predominantly by the states and many malpractice insurers serve only one or a small number of states. Current and recent proposals for federal tort reform such as a nationwide cap on noneconomic damages represent a substantial departure from an uninterrupted historical tradition of state control over this area of law.

There are several indicators that a state is entering a malpractice crisis:

Deteriorating financial performance of insurers. Deteriorating financial statistics (Figure 3) are typically the earliest indication of a malpractice crisis. Over time, insurers should adjust their premiums or underwriting practices to correct problems with profitability. If they raise prices sufficiently, the crisis will be resolved for insurers before it is over for health care providers.

What is a medical malpractice "crisis"?

Currently, there are signs that insurers' financial ratios in many states are stabilizing and some insurers plan no further large increases. But because premiums remain at much higher levels than they were before the crisis, providers perceive the crisis to be ongoing.

Figure 3. Measuring insurers' financial performance

Financial statistic	Explanation
Loss ratio	The ratio of expected liability on claims to dollars collected in premiums.
Combined ratio	A statistic similar to the loss ratio that incorporates information about the insurer's administrative expenses.
Incurred losses	The insurer's estimate of the total value of all claims relating to the policy year.
Operating ratio	A measure comparing premium and investment income to the insurer's loss costs and expenses.
Paid losses	The actual losses paid by the insurer during the policy year.

Decreased availability of insurance. One flavor of malpractice crisis is a crisis of availability: insurers exit the market, deciding it is not profitable enough or is too volatile and unpredictable (22). Alternatively, insurers get tougher with underwriting—they decline to renew policies for doctors who have experienced a claim, do not write any new policies, or write new policies only for the best risks. Withdrawal of insurers was characteristic of the first malpractice crisis, in 1974–1976, when several companies exited the malpractice insurance markets in certain states. (That problem was corrected by the entrance of many new, physician-owned mutuals (27).) It is also characteristic of the current malpractice crisis. In December 2001, St. Paul's, the largest malpractice insurer, withdrew from the market. Two other important sources of insurance, PHICO and Frontier Insurance Group, also left, and the Medical Inter-Insurance Exchange (MIIX) decided to write business only in New Jersey (16). Government may respond to availability problems with special insurance programs such as joint underwriting associations, but if physicians are having to turn to these programs, which are typically more expensive than admitted carriers, it's usually a sign of a problem in the market (23).

Large premium increases. A crisis of affordability occurs when premium costs increase substantially relative to their historical rate of increase (22, 28). Often this is related to insurers exiting the market; those remaining charge more. However, it may occur even with a stable supply of insurance. Affordability problems characterized the second malpractice crisis, in the mid-1980s, and the current crisis. Premiums have been rising in many states since 1999, with some leveling in 2004 (Figure 2). Crises of affordability tend to vary not just across states but also within states by region (urban areas may experience greater increases than rural areas) and clinical specialty (most affected are obstetrics-gynecology, neurosurgery, general surgery, other surgical subspecialties, radiology, orthopedics and emergency medicine).

Provider inability to pass on higher insurance costs to payers: To understand how rising insurance costs are affecting health care providers, it is important to examine both the size of premium increases and what is happening to provider reimbursement. If physicians and hospitals can charge more when their overhead costs increase, there will be no crisis from their perspective. If this pass-through of costs is not possible—for example because a single payer has a dominant market share and refuses to negotiate on this point—then premium hikes hurt providers more.

What is a medical malpractice "crisis"?

Compared to previous malpractice crises, the current era is characterized by greater use of non-fee-for-service reimbursement arrangements and greater payer consolidation. As a result, it is likely much harder for providers to negotiate upward adjustments in reimbursement. Moreover, Medicaid and Medicare reimbursement has been flat or declining for the last several years. The combination of lower income and higher overhead creates a squeeze on providers.

Problems with the malpractice system persist even as malpractice crises come and go. There is enduring dissatisfaction with the medical liability system. Upswings in premiums bring these complaints into sharper relief, pushing the policy debate in the direction of sweeping reform rather than tinkering around the edges. Complaints about the system span its performance on several measures:

- *The system does a poor job compensating patients injured by medical malpractice.* Epidemiological studies of medical injury and malpractice claiming suggest that only about two percent of injuries due to medical negligence become malpractice claims (12, 30).

- *The system has high transaction costs*. For every dollar paid in malpractice insurance premiums, only about 40 cents goes to injured patients (15). The remainder is absorbed by insurers' administrative expenses and litigation expenses. Compared to other compensation systems that rely on administrative rather than legal processes to direct compensation to injured people, such as Social Security Disability Insurance or worker's compensation, these transaction costs are extremely high.

- *Awards in malpractice cases are inequitable*. Many plaintiffs with meritorious claims receive nothing, while others receive awards that seem disproportionate to the severity of their injury. Moreover, plaintiffs with similar injuries receive quite different awards, even in the same jurisdiction (8, 29).

- *The system focuses on the misdeeds of individual healthcare providers, but medical errors are often due to breakdowns in whole systems of care*. There is no systems orientation in the liability system, despite the growing awareness of the role of systems in patient safety (11). It is difficult to hold a hospital or other healthcare system liable for a medical error so malpractice awards are usually levied against individual physicians.

- *There is no real evidence that the medical liability system deters negligent care*. The tort system tends to be defended primarily on the basis of its deterrent effect, but the available evidence suggests that deterrence of medical error is limited at best (20).

- *The system has perverse effects on patient safety initiatives*. Rather than deterring error, a heated liability environment may actually impede patient safety improvement by discouraging physicians from participating in initiatives such as adverse event reporting which may help analysts learn why medical errors occur (19, 25).

Patient safety advocates contend that the current focus on tort reform does nothing to address the real "malpractice crisis": medical errors.

Groups that are concerned with patient rights and patient safety contend that the current policy focus on tort reform and calming insurance markets misses the real malpractice crisis, which is the high prevalence of error in medicine. Today's malpractice crisis differs from previous crises in that there is a greater public understanding of how often medical error occurs. The Institute of Medicine's 2000 report, *To Err Is Human: Building a Safer Health System*, brought wide attention to the issue, estimating that 44,000 to 98,000 hospital deaths per year are attributed to medical errors.

What causes malpractice crises?

The new focus on medical errors has changed the tenor of the policy debate about malpractice. Providers have a relatively more difficult time making the case that malpractice litigation is unreasonable (21) and there is a greater demand for reforms that are also safety-enhancing (26). The focus on patient safety has also led state legislators and federal regulators to impose disclosure requirements of adverse events to patients. This raises the stakes of the malpractice crisis for health care providers because widespread disclosure would result in a bigger pool of patients who are aware that they suffered an adverse event and may decide to sue. In short, the patient safety movement has affected both the malpractice environment and the kinds of policy responses that the public is willing to support.

What causes malpractice crises?

Stakeholder groups have rallied behind one of two genesis stories. Physician, hospital and insurer organizations usually characterize the malpractice crisis as being due to rising litigation costs. They argue that the last few years have seen large increases in the average amount paid out on claims (claim severity), the number of claims filed (claims frequency), or both. In contrast, attorney and consumer groups usually offer explanations that center on insurers. They argue that the insurance industry naturally undergoes fluctuations in its fortunes, a phenomenon called the insurance cycle. They point to factors such as decreased investment returns and imprudent pricing decisions by insurers as factors that trigger the onset of unfavorable swings in the market.

What characterizes the arguments of all of these groups is that they stress that *either* claims costs *or* insurance industry factors have driven the crisis, not both. The best evidence suggests that to the contrary, the crisis has been driven to some degree by both of these phenomena, and that they may be interrelated.

Studies of litigation costs should be interpreted carefully in light of several measurement issues. When interpreting analyses of trends in claim severity and claims frequency, these issues should be taken into consideration (Figure 4).

Figure 4. Measurement issues in analyzing trends in claim severity and claims frequency

Measure	Measurement issue
Award amounts	Award amounts should be adjusted for inflation using a general inflation measure such as the GDP inflator.
Claims frequency	Claims frequency data should be adjusted for the number of practicing physicians by expressing them as the number of claims per physician.
Claim severity vs. insurer losses	Claim severity and insurer losses are different measures and cannot be used interchangeably. Claim severity figures show the average payment per paid claim, based on data about specific claims. Insurer loss data describe the insurer's total expected or actual payouts. When losses go up, it could be because of higher claim severity, higher claims frequency, or both. One type of insurer loss statistic, called incurred losses, represents the insurer's estimate of its total liability for claims relating to that year, not the amount it actually paid. The estimate may prove inaccurate.
Jury verdict amounts	Jury awards may not represent what an insurer actually pays in a case because many verdicts are later reduced. Also, average jury verdict amounts are not representative of average settlement amounts.

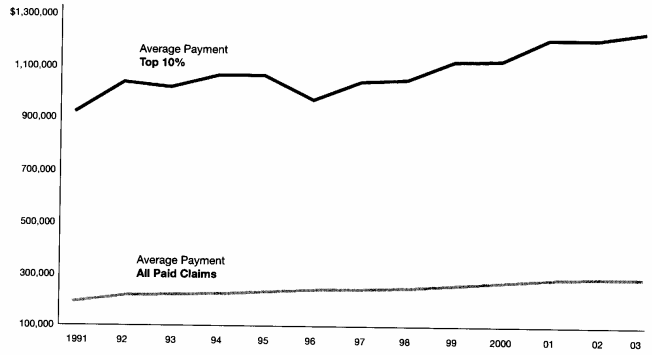
What causes malpractice crises?

Rising claims costs—driven by an increase in average payouts not claims frequency—have contributed to rising premiums, but do not explain the sudden spike in premiums around 1999–2000.

The hypothesis that increased claims costs have contributed to the recent increases in premiums and insurer exits is supported by several academic studies as well as a 2004 report by the National Association of Insurance Commissioners (22, 23, 28, 31). These factors, however, do not appear to have as much explanatory power for the current crisis as for the crises of the mid-1970s and mid-1980s, which were driven by surges in both claims frequency and claim severity.

Figure 5 illustrates trends in the average severity of paid claims using National Practitioner Data Bank data reported in a recent study (14). The National Practitioner Data Bank collects mandatory insurer reports of all malpractice claims on which a payment was made on behalf of physician defendants. The study found that the average severity of paid claims has increased since 1991; however, the rate of growth did not increase during the malpractice crisis period. Total growth in severity was 52 percent in real terms for the entire study period (1991–2003), but only six percent between 2000 and 2003. The increase would be much higher (88 percent) if the figures were not adjusted for inflation (13). Although the top ten percent of awards have grown more in absolute dollar terms, the highest rate of growth has actually been in medium-sized awards. These findings suggest that the burden of claims costs on insurers is growing over time, but did not spike around the time malpractice insurance premiums began to rise rapidly. Hence, other factors probably influenced the recent sharp increases in premiums.

Figure 5. Amount of average paid claim, 1991–2003



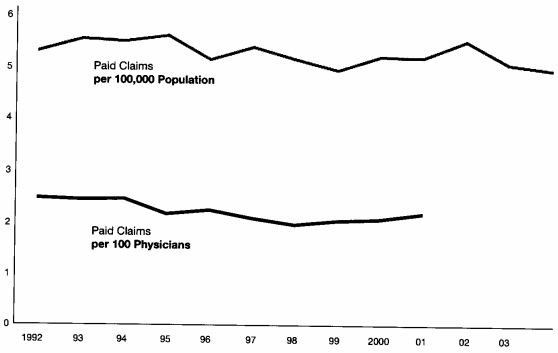
Source: National Practitioner Data Bank data reported in Chandra et al., 2005. All dollar values are adjusted to 2003 dollars.

What causes malpractice crises?

The national claim severity figure masks substantial state-to-state variations. A study of closed claims in Florida found that average severity among paid claims increased significantly between 1999 and 2003 (34). In contrast, a study of Texas closed claims found that severity among "large" paid claims (payments greater than $25,000 in 1988 dollars) was essentially flat over the 1999–2002 period—before the state's damages caps were instituted (7). Although these studies are not directly comparable because the Texas study excluded small payments, the results are strongly indicative of variations across states.[1]

With regard to claims frequency, there is no evidence that an increase in the number of malpractice claims has contributed to the current malpractice insurance crisis. The Data Bank study found no significant nationwide increase in the number of paid claims between 1991 and 2003 after adjusting for population changes (Figure 6). These findings are corroborated by state-specific studies. A study of two counties in Illinois in the 1994 –2004 period similarly found no upward trend in frequency after adjusting for changes in the number of physicians (33). Likewise, the aforementioned Florida study found no increase in the number of paid claims from 1999 to 2003 after adjusting for growth in the number of doctors (34) and the Texas study found that per-physician claims frequency actually declined from 1999 to 2002 (7).

Figure 6. Trends in per-capita frequency of paid malpractice claims, 1991–2003



Source: National Practitioner Data Bank data reported in Chandra et al., 2005; population data obtained by personal communication with the author of that report; and physician supply data from the Bureau of Health Professions Area Resource File.

[1] Including small payments would likely have only a modest effect on the average.

What causes malpractice crises?

The statistical relationship between insurers' claims payments and malpractice premiums is weakly positive. To understand the contribution of claims payments to the malpractice crisis, it is useful to understand the relationship between insurer losses and premiums. Insurers say that their pricing decisions are driven by their forecasts of liability costs in the period covered by the policy. Actuaries forecast these costs based on historical loss data as well as their knowledge of relevant environmental factors in the coming period, such as new tort reforms. This account of how policies are rated suggests that premiums should closely track insurer losses, assuming the actuarial estimates are reasonably accurate.

Some stakeholder groups, however, dispute this account, claiming that premium increases bear no association with trends in losses. They have prepared descriptive analyses suggesting that losses have been stable over the past several years while premiums have gone up (1). Some of these reports have only looked at paid losses, leading insurers to object that incurred losses (the total amount the insurer expects to pay once all claims for which it has exposure have been brought and closed) are a better measure. Additionally, some of these reports have only looked at the largest companies (3), which may not be representative of the experiences and practices of all companies.

A recent study using data on claims payments from 1992 to 2002 from the National Practitioner Data Bank is interesting for its lack of significant findings (4). The study examined the statistical association between payments and premiums by estimating a regression model in which payments were the only explanatory variable. The regression coefficient for the payments variable was positive, but did not achieve conventional levels of statistical significance.

Of note, none of these analyses controls for other factors that may influence premiums. They simply examine the association between payments or losses and premiums. The lack of a strong statistical relationship suggests that other variables are also influential.

The insurance cycle has contributed to the current crisis. Insurance markets undergo periodic business cycles. The insurance cycle has been the subject of considerable attention from economists, but they still argue about why the cycle occurs (Figure 7).

At least one expert analysis suggests that decreased investment returns—an element of the insurance cycle—underlies the current crisis (5). But these declines do not explain the magnitude of premium increases or their variation across states during the malpractice crisis. Thus, investment returns are at best only a partial explanation.

Another strand of the insurance cycle argument relates to insurer pricing decisions. Critics of the industry charge that insurers seeking to maximize their business volume priced their policies unreasonably low in the 1980s and 1990s, taking insufficient notice of their potential liability for incurred-but-not-reported claims. While at lease one study supports this argument (9), it better explains the failure of particular companies than increases in prices charged by the remaining companies.

The insurance cycle should not be considered in isolation from claims costs as an explanation for the malpractice crisis. The two are related. Because of the possibility that external shocks such as large increases in claims costs contribute to the insurance cycle (Figure 7), it is reasonable to see a relationship between insurance cycle and claims costs explanations for the malpractice crisis. However, some still present the insurance-cycle as a competing explanation.

What causes malpractice crises?

Figure 7. Understanding the insurance cycle

Insurance markets cycle through periods of low prices and ample supply (soft markets) and periods when prices are high and supply is tight (hard markets). Soft-market periods are characterized by relatively low claims costs and relatively high investment returns. During soft markets, insurers may loosen their underwriting standards and lower their prices in order to attract more business. The more premiums they collect, the more they are able to invest in favorable stock and bond markets.

The cycle turns when insurance company actuaries begin to realize that insurers' financial resources are not going to be sufficient to cover their losses. Companies report signs of financial distress, such as inadequate reserves and deterioration in the financial ratios that measure profitability. They may raise premiums, adopt stricter underwriting standards (turning away physicians they judge to be poor risks), stop taking on any new business or threaten to exit the malpractice insurance market altogether. Health care providers become alarmed at the decreasing affordability and availability of insurance. The situation typically stabilizes within a few years due to some combination of premium increases, reforms that limit insurers' losses, shifts in the amount of market competition or improvements in investment returns.

Insurance cycles reflect a forecasting error, a gap between what insurers thought their losses would be over the short term and what they actually evolved to be. There is disagreement among insurance scholars about why forecasting errors occur. A key point of controversy is the extent to which errors stem from external shocks to the system, such as an unanticipated industry-wide increase in the frequency or average cost of malpractice claims or a downturn in the equity and bond markets. The consequences of such changed circumstances can be severe for medical malpractice insurers because of the long tail of malpractice claims—the fact that claims often are not filed until 2–3 years after the alleged malpractice occurs. The tail problem means that changed assumptions about losses affect not only the claims that have been brought in a given year, but also the claims that are yet to come.

External shocks are believed to lead to a problem called capacity constraint. The amount of capital a company holds limits the amount of insurance it can offer at one time, because the company needs to have money to put into reserve. It is relatively expensive for companies to raise new capital, so if an insurance company loses a lot of capital through a decrease in investment returns or a big increase in claims costs, rather than raising new capital it may just decide to offer less insurance. As the supply of insurance shrinks, the companies that do offer insurance can charge higher prices without fear of losing out to competitors.

While some scholars believe that it is primarily unforeseen external factors that drive insurance cycles, others blame insurance companies. They argue that below-cost prices during soft markets are the result of unrealistic and imprudent actuarial assumptions, and that above-cost prices during hard markets reflect insurers' attempts to maximize profits by charging more than is reasonable. These hypotheses are difficult to test empirically. There does appear to be a temporal correlation, however, between changes in interest rates, changes in litigation costs and the onset of malpractice crises.

In the policy debate over the causes of the malpractice crisis, insurance-cycle explanations are often discussed as though they are wholly separate from an alternative explanation, rising litigation costs. But because one of the fundamental questions surrounding insurance cycles is the extent to which they are driven by external factors such as upswings in claims costs, they shouldn't be considered mutually exclusive explanations.

Recommended reading: (5, 23, 27)

There is evidence that each of these drivers has played a role. The most reasonable conclusion suggested by the evidence is that increased claims costs, inadvised insurer business decisions, decreased investment returns and other insurance-market dynamics have all contributed to this malpractice crisis. These factors also interact. For instance, both poor business decisions and external shocks such as rising litigation costs may contribute to an insurance cycle. Genesis stories that focus on just one explanation, or frame the explanations as mutually exclusive, miss the mark.

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Appendix I References

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Notes

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Medical malpractice: Impact of the crisis and effect of state tort reforms

See companion Policy Brief and Primer available at *www.policysynthesis.org*

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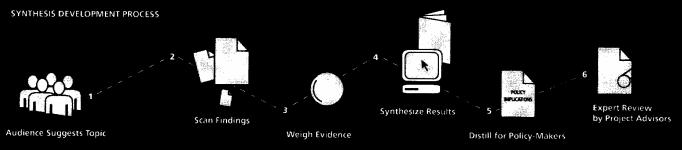


Introduction

Many U.S. states are now in their fifth year of a medical malpractice "crisis", a period of volatility in the malpractice insurance market characterized by above average increases in premiums, contractions in the supply of insurance and deterioration in the financial health of carriers.[1]

Improving insurer financial ratios suggest that the malpractice crisis is now abating in some states, but malpractice crises are a recurring problem. This has been the third period of rapidly rising premiums in the last 30 years, following crises in the mid-1980s and mid-1970s. States, which are responsible for regulating malpractice insurance, have enacted a variety of reforms to prevent or temper malpractice crises, but there is a paucity of reliable information available to policy-makers about the effects of these reforms and the impact of the malpractice crisis on health care delivery. While a voluminous number of reports have been produced, most are not based on rigorous analysis. There are several studies that appear trustworthy, however, and the substantive findings in this Synthesis Report are based on those studies.

This Synthesis Report examines the evidence on these questions:

- **How does a volatile malpractice environment affect health care delivery?**
- **What has been the impact of state tort reforms on premiums, claims frequency, claims payouts and physican supply?**

While the weight of the evidence suggests that the malpractice crisis has had a modest effect on physician supply, the evidence base is not yet adequate to draw conclusions about whether patients' access to high-risk services has been compromised as a result. The literature evaluating state tort reforms, while problematic due to methodological issues, does offer some useful findings. Caps on noneconomic damages are the most common and most effective reform, although they disproportionately burden the most severely injured patients.

This Synthesis Report is one in a series addressing medical malpractice insurance issues. The series also includes a Primer, which describes how medical malpractice insurance works and the causes of malpractice crises, and a Policy Brief, which summarizes the findings of this Synthesis Report.

[1] Some crises are characterized by both premium increases and supply contractions, while others have one but not both of these phenomena.

Findings

How does a volatile malpractice environment affect health care delivery?

Physician and insurer groups have claimed that rising insurance costs have led physicians to reduce services by:

- Retiring early.
- Relocating their practice to other states where insurance costs are lower.
- Restricting their scope of practice to exclude or reduce high-risk procedures or avoid high-risk patients. For example, obstetrician-gynecologists are said to be confining their practice to just gynecology, or to normal but not high-risk deliveries.

These claims have been supported more by anecdote than by hard data, particularly in the early years of this malpractice crisis. More reliable evidence has begun to emerge, but remains limited. The extent to which these physician responses are occurring is a key policy issue because it potentially broadens the malpractice crisis from a problem for providers and malpractice carriers to a consumer health care access issue.

Researchers can evaluate these claims in several ways, but each is problematic (see Appendix II). While they have shortcomings, administrative datasets such as the American Medical Association's Physician Masterfile are the best available sources of information about trends in the number of practicing physicians over time. Physician survey data are a better source of information about why physicians choose to stop practicing or move their practice, but because of response bias (discussed below), they produce less reliable estimates of the number of physicians who do so.

A number of studies have used one of the physician databases to measure physician supply and tested the relationship between supply and measures of the liability climate using multivariate regression analysis (Figure 1).[2] Some of these studies have directly modeled the relationship between physician supply and indicators of the litigation environment, such as insurance premiums, claims frequency, or claims payments in a state. Others have used tort reform laws to measure malpractice risk, a less direct measure of the liability climate. A key issue in physician-supply studies is adequately controlling for various market characteristics, aside from liability, that may affect physician supply. A few studies have used "difference-in-difference" analysis, which compares the amount of change in physician supply in each state over time, to implicitly control for all state characteristics. Most studies use cross-sectional analyses that explicitly control for state characteristics by including them as explanatory variables in the model. Both are good methodologies if all the relevant variables are included in the model and the data are good measures of the variables. The studies we characterize as particularly strong have these features.

Three studies have found a significant association between malpractice risk and physician supply, three had no significant findings and two had mixed results. The results did not vary systematically with the particular measure of malpractice risk used: among studies modeling the effect of caps on noneconomic damages and other tort reforms on physician supply, for example, two studies had significant findings, one did not, and two were mixed.

[2] Multivariate regression is a statistical technique used to test the effect of one explanatory variable (e.g., malpractice premium levels) on an outcome variable (e.g., state physician-to-population ratio) while holding many other variables constant. It is useful for examining variations in physician supply across states because it lets the analyst control for characteristics on which states may differ and which may affect physician supply—for example, the average gross income of physicians in the state. Just examining the association between malpractice insurance premiums and physician supply in a state without controlling for these other "confounding variables" might lead to a spurious conclusion that variations in supply are due to differences in premiums.

Findings

Figure 1. Results of controlled studies on effect of malpractice environment on physician supply†

Authors	Malpractice risk measure	Data years	Findings
Baicker & Chandra 2005 (2)	(1) Premiums (2) Claims payments	1993–2001	**Not significant.** Neither premiums nor payments were significantly associated with overall physician supply. Methodological comments: **Strong analysis overall.** *Strengths:* Controls for a good range of confounding variables. Separately tests effects on physician subgroups. *Limitations:* Inappropriate averaging of company-specific premium data.
Kessler et al. 2005 (23)	"Direct" and "indirect" tort reforms	1985–2001	**Significant.** Direct reforms (e.g., caps on damages) were associated with three percent higher growth in physician supply after three years. The effect size varied by specialty, e.g., 12 percent difference for emergency medicine physicians but no significant difference for surgeons or radiologists. The effect was mainly due to retirements and entries rather than inter-state relocations. Methodological comments: **Strong analysis overall.** For more information, see Appendix III.
Matsa 2005 (27)	Caps on damages	1970–2000	**Not significant.** The association between caps and overall physician supply was not significant, although caps did increase supply 10–12 percent from 1970 to 2000 for specialists in extremely rural areas. Methodological comments: **Strong analysis overall.** For more information, see Appendix III.
Encinosa & Hellinger 2005 (13)	Caps on damages	1985–2000	**Mixed.** Counties subject to any damages cap (whether $250,000 or higher) had two percent more physicians per capita than counties without caps (three percent in rural counties); the difference was statistically significant. However, results not published in the paper showed, counterintuitively, that the $250,000 cap was not significant but the higher cap was. Methodological comments: **Fairly strong analysis overall.** For more information, see Appendix III.
Erus 2004 (14)	(1) Premiums (2) AMA deems state in "crisis" (3) # claims (4) Claims payments	1997–2002	**Not significant.** None of the indicators of malpractice risk showed a significant association with physician supply. Methodological comments: **Preliminary analysis, not yet perfected.** Model requires more work before it can be deemed reliable. *Strengths:* Examines data through middle of current malpractice crisis. *Weaknesses:* State-level model did not identify any significant predictors of physician supply, and some findings are counterintuitive.
Gius 2000 (17)	Premiums	1994–1996	**Significant.** States with above-average medical malpractice insurance premiums had significantly fewer physicians per capita. Methodological comments: **Fairly strong analysis overall.** *Strengths:* Model estimation method controls for endogeneity (two-way causation) between physician income and physician supply. *Weaknesses:* Exact nature of premium data is unclear. Does not examine dynamics during times of malpractice crisis.
Hellinger & Encinosa 2003 (20)	Caps on damages	1985–2000	**Significant.** States with caps have, on average, 12 percent more physicians per capita than states without caps, although physician supply grew in both types of states. Methodological comments: **Not a strong analysis overall.** For more information, see Appendix III.
Klick & Stratmann 2003 (24)	Caps on damages	1980–1998	**Mixed results.** Counterintuitively, the $250,000 cap was not significant but the $500,000 cap was. States with the higher cap had three percent more doctors per 100,000 population than states without them. Methodological comments: **Not a strong analysis overall.** For more information, see Appendix III.

† The dependent variable in all studies is the number of physicians in the state or number per capita as listed in the American Medical Association Physician Masterfile, except for Baicker and Chandra, who modeled the difference in the log number of physicians between 1993 and 2001. The strongest studies are cited in bold print.

Findings

The strongest studies have found that the malpractice environment has had only small or no effects on the supply of physician services overall, although the impacts in certain specialties and in rural areas are somewhat higher. The most informative and reliable results may be those of Baicker and Chandra (2) because their study used a direct measure of liability costs (professional liability insurance premiums) rather than an indirect measure (tort reforms) and estimated a well-specified model. That study found no significant association between premiums and physician supply. The strongest study using caps on damages as the measure of the liability climate is that of Kessler and colleagues, who found that caps were associated with three percent higher growth in physician supply three years after they were adopted (23). Most studies have not been designed to test whether some medical specialties are affected more than others, but Kessler and colleagues' study did find some inter-specialty differences.

Survey studies also shed light on the relationship between liability costs and physician supply. As discussed in Appendix II, survey studies have both strengths and weaknesses compared to other approaches. The biggest weaknesses are low response rates and risk of response bias. One strong survey study (with a high response rate, strong sampling design and well-designed survey instrument) is a 2003 study of physicians in specialties with high malpractice risk in Pennsylvania, one of the states most severely affected by rising insurance costs (30). This study found that only a small proportion of specialists definitely planned to retire early (seven percent) or relocate their practice out of state (four percent) within the next two years because of the cost of professional liability insurance. Larger proportions (32 percent and 29 percent, respectively) reported that they would likely do so. Forty-two percent of the specialists reported that they had already restricted their scope of practice, and 50 percent said they were likely to (continue to) do so over the next two years.

This survey had a response rate of 65 percent, but may still have suffered from bias due to physicians' desire to give a socially correct response. Additionally, the sampling scheme was designed to produce a representative sample of physicians at highest malpractice risk, but is not generalizable to all specialties. Similarly, Pennsylvania is broadly representative of other states experiencing a malpractice crisis, but findings from Pennsylvania cannot be generalized to the national level.

Few studies have directly examined whether access to high-risk services has been affected; the evidence base is not yet sufficient to answer this question. Direct evidence of effects on access to care would consist of data showing that measures of patient access, such as travel times and wait times for specialist services, have worsened in states affected by rising liability costs, and that this trend is unrelated to other things going on in those states. Evidence of changes in the supply of physicians constitutes only indirect evidence of an access-to-care problem, because it is possible that the baseline supply of providers was sufficiently large that patients still have good access to care even after some physicians leave practice.

In at least one survey study (30), physicians have reported that their patients have experienced increased travel times and wait times for specialist care. Such problems reportedly resulted both from malpractice pressure and from other factors, such as managed care restrictions. Other research evidence does not indicate that significant reductions in access to care have occurred. Two studies have examined whether rates of utilization or provision of high-risk procedures are lower in states with heated liability environments than in other states. One, an uncontrolled, descriptive analysis, found that the number of doctors performing craniotomies, cesarean sections and vaginal deliveries with complications in Florida, a state severely affected by rising insurance costs, decreased during the period of the latest malpractice crisis compared to 1997–2000. Rates of these

procedures and access to care (travel times), however, were largely unaffected (11). This study did not control for other factors that may have influenced the supply of doctors performing these services in Florida over the study period.

The other, a well-designed study that controlled for a range of factors that may affect health services utilization, examined whether rates of several procedures varied across states according to either malpractice insurance premiums or payments made in malpractice cases (2). The authors found no significant differences in rates of percutaneous coronary interventions, angiography, coronary artery bypass graft, cesarean section, transurethral prostatectomy, or radical prostatectomy. Mammography rates were higher in the states with higher premiums and payments. An important limitation of this study is that the procedure rates were for Medicare patients only. Doctors might be more inclined to avoid high-risk procedures for younger patients because they are statistically more likely to sue than elderly patients (6).

Longer-term effects on physician supply may occur that have not been documented. The studies discussed focus on short-term effects of changes in the malpractice environment on physician supply. There may also be longer-term effects. For example, deteriorations in the liability environment may dissuade college students from entering medical school, medical students from entering certain specialties, or medical residents from setting up their first practice in a state with high malpractice insurance premiums.

One survey study suggests that residents who trained in Pennsylvania during the malpractice crisis were much less likely to stay in the state after residency than residents who trained there when the liability climate was calmer (29). In a state that is undersupplied with young physicians to begin with, the exit of newly qualified physicians could pose a long-term problem. There is no evidence that interest in particular specialties is correlated with perceived malpractice risk. Rather, medical students tend to choose their specialty based on a host of factors, including income and lifestyle (16, 31).

"Defensive medicine" is difficult to measure, but is likely to become more prevalent when physicians perceive heightened malpractice risk.[3] Pinning down the extent, costs and consequences of defensive medicine is notoriously difficult. In addition to the problem of trying to extrapolate national, systemwide costs on the basis of measurements drawn from a limited set of procedures, it is difficult to ascertain which procedures, tests, and referrals (called "assurance behaviors") are ordered primarily out of legal concerns rather than medical judgment (5, 41). Physicians may have more than one reason for ordering a test, and it can be difficult to draw a clear line between the desire to avoid lawsuits and the desire to make absolutely sure that the patient receives an accurate diagnosis and all treatment that might benefit him (see Appendix II for further discussion of this issue).

One strong methodology for measuring defensive medicine is to compare rates of medical procedures that physicians might be inclined to order out of legal fear, such as magnetic resonance imaging and cesarean section, across geographic areas with different liability climates, controlling for other factors that might account for the differences in utilization of these procedures. Three well-designed studies have found that greater malpractice risk (measured by premiums or claims

[3] Defensive medicine can take two forms. What is conventionally described as defensive medicine are "assurance behaviors," in which physicians order tests, referrals, and procedures that are not medically justified primarily for the purpose of reducing legal risk. But the "avoidance behaviors" discussed earlier in the Synthesis – withdrawing from practice or restricting scope of practice to exclude high-risk patients or procedures – could also be considered forms of defensive medicine. This section of the Synthesis focuses on assurance behaviors.

frequency in the area) was associated with small but statistically significant increases in the incidence of cesarean sections (12, 26, 44). Other studies have had mixed results, with some providing corroborating evidence (18, 19, 36) and others finding no difference in cesarean rates (3, 37).

Although the methodological challenges probably mean that there will never be a completely accurate estimate of the extent of defensive medicine, studies consistently find that assurance behaviors are widespread and become even more so during malpractice crises (21, 41, 45).

Two relatively recent, well-designed studies provide illustrative data. A 2003 survey of high-risk specialists in Pennsylvania found that 93 percent reported that they sometimes or often engaged in at least one of six assurance behaviors (41). Fifty-nine percent reported often ordering more diagnostic tests than were medically indicated; 52 percent often made unnecessary referrals to specialists; 33 percent prescribed more medications than were medically indicated; and 32 percent suggested unnecessary invasive procedures such as biopsies to confirm diagnoses. Physicians who were not confident about the adequacy of their liability coverage and physicians who perceived their insurance premiums to be very burdensome were significantly more likely to report these behaviors.

One often-cited study used Medicare claims data and strong statistical methods to examine whether patients in states without strong tort reforms received more health care services than patients with the same diagnoses in states that had such reforms (21). It found that states that adopted "direct" tort reforms such as caps on damages experienced five percent slower growth in expenditures for patients admitted to the hospital for myocardial infarction, and nine percent slower growth in spending on patients with ischemic heart disease, between 1984 and 1990. This study has been somewhat controversial because the authors attempted to extrapolate national defensive-medicine costs from these two diagnoses (46) and a subsequent study failed to replicate the findings for other diagnoses (7). The study's findings are probably not generalizable to all conditions or all patients, but its estimates for these two common conditions are quite defensible. Unlike the survey study discussed above, this study did not attempt to ascertain whether the extra costs generated in high-liability states were associated with care that the treating physicians found necessary and beneficial or care that was ordered primarily for defensive purposes.

What has been the impact of state tort reforms on premiums, claims frequency, claims payouts and physican supply?

In response to the last three malpractice crises, states have implemented a limited range of tort reforms. The objective of conventional tort reforms (Figure 2) is to reduce the overall costs of malpractice litigation. The specific mechanisms for achieving this goal are: (1) erecting barriers to bringing suit (statutes of limitation/repose; attorney contingency-fee reform) or reaching trial (pretrial screening panels); (2) limiting the amount plaintiffs may take as an award (caps on damages, collateral-source rule reform); and (3) altering the way damages awards are paid (joint-and-several liability reform, periodic payment).

Findings

Figure 2. Tort reforms commonly adopted by states

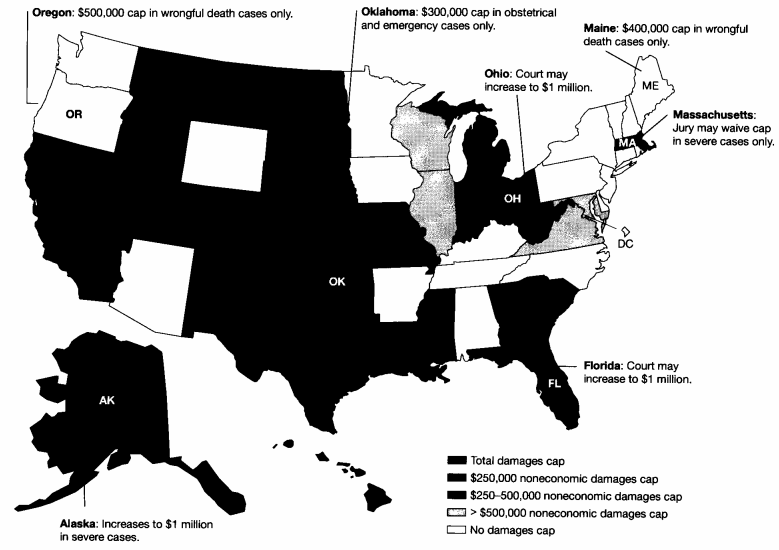
Reform	Description
Caps on damages	Caps on damages limit the amount of money that a plaintiff can take as an award in a malpractice suit. The cap may apply to noneconomic damages ("pain and suffering"), total damages (including both noneconomic damages and economic loss such as medical expenses and lost wages), or only punitive damages (damages intended to punish the defendant for particularly wanton conduct; very rare in malpractice cases). The cap may apply to the plaintiff, limiting the amount she may receive, or to each defendant, limiting the total amount for which each may be liable.
Joint-and-several liability reform	In cases involving more than one defendant, such as a physician and a hospital, this reform limits the financial liability of each defendant to the percentage fault that the jury allocates to that defendant. Without this reform, the plaintiff may collect the entire amount of the judgment from one defendant if the other(s) default on their obligation to pay, even if the paying defendant bore only a small share of the responsibility for what happened to the plaintiff.
Statutes of limitations/ statutes of repose	These reforms limit the amount of time a patient has to file a malpractice claim, typically to two or three years. Statutes of limitations bar suits unless they are filed within a specified time after the injury occurs or is discovered. Statutes of repose bar suits unless they are filed within a specified time after the medical encounter occurred, regardless of whether an injury has yet been discovered.
Attorney contingency-fee reform	This reform limits the amount of a malpractice award that a plaintiff's attorney may take in a contingent-fee arrangement. The limitation is typically expressed as a percentage of the award; it may also incorporate a maximum dollar value.
Collateral-source rule reform	This reform eliminates a traditional rule that if an injured plaintiff receives compensation for her injury from other sources, such as health insurance, that payment should not be deducted from the amount that a defendant who is found liable for that injury must pay.
Pretrial screening panels	Pretrial screening panels review a malpractice case at an early stage and provide an opinion about whether a claim has sufficient merit to proceed to trial. Typically, a negative opinion does not bar a case from going forward, but can be introduced by the defendant as evidence at the trial.
Periodic payment	This reform allows or requires insurers to pay out malpractice awards over a long period of time, rather than in a lump sum. This enables insurers to purchase annuities (sometimes called "structured settlements") from other insurance companies which cost less than paying the whole award up front. Insurers are also able to retain any amounts that the plaintiff does not actually collect during her lifespan.

Tort reform has been on the legislative agenda in nearly all states that are experiencing volatility in their liability insurance market. With few exceptions, the reforms that states have adopted (as well as the reforms currently under consideration in the Congress) have reprised approaches taken to the crisis of the mid-1980s and have been limited in their aims and scope. Some states that did not pass tort reforms in the 1980s have recently done so; others have added to or strengthened reforms passed earlier.

Caps on damages have received the greatest attention by far. Twenty-six states now have some type of limitation on damages, mostly applying to the noneconomic component of awards (Figure 3).

Findings

Figure 3. Caps on noneconomic and total damages by state as of April 2006



Source: Author's analysis

Studies of the effects of these reforms tend to burgeon around times of malpractice crisis. There is a cluster of studies from the mid-1980s crisis and its aftermath and an emerging literature from the current crisis period. Most of the older studies are methodologically strong (they use strong econometric methods to analyze the effect of caps while controlling for important confounding variables). Their results have continued relevance, although the market and legal environments have changed somewhat over time. Most of the evidence concerning reforms other than caps on damages comes from these earlier studies. The newer studies vary in quality, but some valuable contributions to the literature have appeared over the last two years. The newer studies have focused primarily on evaluating caps on damages, because of the political interest in that reform.

Findings

Aside from caps on damages, most of these reforms have had limited efficacy (Figure 4). Two other reforms have had some effect. Joint-and-several liability reform has been found to constrain the growth of insurance premiums (but has no significant effect on claims payouts or physician supply). Study findings regarding shorter statutes of limitations/repose are mixed, but some strong studies have found an effect on claims frequency and premiums (effects on physician supply have not been tested, and there was no effect on claims payouts).

Attorney contingency-fee limits, despite their political appeal, have not been shown to have significant effects in the majority of studies. Collateral-source offsets, pretrial screening panels and periodic payment too, have rarely been found to have any significant effects. The continued interest in these reforms is striking given the lack of evidence of their effectiveness. (For information on the methodological strengths and weaknesses of relevant studies, see Appendix III.)

As shown in Figure 4, the size of the evidence base concerning the efficacy of reforms varies across reforms. Some reforms have been extensively tested against each of the outcomes of interest (premiums, physician supply, claims payouts, and claim frequency). The effect of other reforms on some of the outcomes has not yet been tested. For example, no studies have examined whether joint-and-several liability reform affects claims frequency.

The efficacy of caps on damages has been hotly disputed, and much of the evidence used in the policy debate is not based on rigorous analysis. Several methodological limitations should be considered when assessing the impact of caps, particularly their effects on insurance premiums.[4] (These issues are discussed in greater detail in Appendix II):

- Simple descriptive studies are much more prevalent than controlled studies.
- Comparison groups are sometimes constructed inappropriately. For example, states with recently adopted caps may be compared to a group that includes both states with older caps and states with no caps.
- Analyses may group states with different types of caps together, making it difficult to determine which type is causing observed effects.
- Information on trends in premiums or claims payouts may be presented without adjusting for the number of physicians in the population.
- Statistics on "average premiums" in a state may present a simple average rather than a weighted average incorporating market-share information.
- Data on trends in premiums, insurer losses, or award average size may not be adjusted for inflation.

Evidence about the impact of caps on average awards, claims frequency, insurance premiums, or physician supply that derives from simple state-to-state comparisons is not reliable. Inferences about the effects of caps should be drawn only on the basis of findings from well-designed, controlled studies. Fortunately, there are several such studies (see Appendix III). Their findings have varied, however.

[4] A more detailed explanation of these methodological problems can be found in Michelle M. Mello and David M. Studdert, *Understanding Medical Malpractice Damages Caps*, working paper 2006.

Findings

Figure 4. Results of controlled studies of the impact of tort reforms†

	Significant decrease in claims payouts?	Significant decrease in claims frequency?	Significantly lower liability insurance premiums?	Significant increase in physician supply?
Damages cap‡	**YES:** ***Danzon 1984 (8)*** ***Danzon 1986 (9)*** ***Sloan et al. 1989 (39)*** Blackmon & Zeckhauser 1991(4)* Viscusi & Born 2005 (49)* **NO:** ***Zuckerman et al. 1990 (52)*** Viscusi et al. 1993 (50)*	**YES:** No studies **NO:** ***Zuckerman et al. 1990 (52)***	**YES:** ***Zuckerman et al. 1990 (52)*** Danzon et al. 2004 (10) ***Thorpe 2004 (43)*** Viscusi & Born 2005 (49) **NO:** Sloan 1985 (38) ***Zuckerman et al. 1990 (52)*** Blackmon & Zeckhauser 1991 (4)* Viscusi et al. 1993 (50)	**YES:** Klick & Stratmann 2003 (24)¶ Encinosa & Hellinger 2005 (13)¶ Hellinger & Encinosa 2003 (20) **NO:** ***Matsa 2005 (27)***
Joint-and-several liability reform	**YES:** No studies **NO:** Blackmon & Zeckhauser 1991 (4)* Viscusi et al. 1993 (50)*	No studies.	**YES:** Blackmon & Zeckhauser 1991 (4) Viscusi et al. 1993 (50)¶ Danzon et al. 2004 (10) **NO:** ***Thorpe 2004 (43)***	**YES:** No studies. **NO:** Klick & Stratmann 2003 (24)
Statutes of limitations/ repose	**YES:** ***Danzon 1984 (8)*** **NO:** ***Sloan et al. 1989 (39)*** ***Zuckerman et al. 1990 (52)*** Blackmon & Zeckhauser 1991 (4)*	**YES:** ***Danzon 1986 (9)*** ***Zuckerman et al. 1990 (52)*** **NO:** ***Danzon 1984 (8)***	**YES:** ***Zuckerman et al. 1990 (52)*** **NO:** Sloan 1985 (38) Blackmon & Zeckhauser 1991 (4)	**No studies.**
Attorney contingency-fee limit	**YES:** No studies. **NO:** ***Danzon 1984 (8)*** ***Danzon 1986 (9)*** ***Sloan et al. 1989 (39)*** ***Zuckerman et al. 1990 (52)*** Blackmon & Zeckhauser 1991 (4)*	**YES:** No studies. **NO:** ***Zuckerman et al. 1990 (52)***	**YES:** No studies. **NO:** Sloan 1985 (38) ***Zuckerman et al. 1990 (52)*** Blackmon & Zeckhauser 1991 (4) ***Thorpe 2004 (43)***	**YES:** No studies. **NO:** Klick & Stratmann 2003 (24)
Collateral-source offset§	**YES:** ***Danzon 1984 (8)*** ***Danzon 1986 (9)*** **NO:** ***Sloan et al. 1989 (39)*** ***Zuckerman et al. 1990 (52)*** Blackmon & Zeckhauser 1991 (4)*	**YES:** ***Danzon 1986 (9)*** **NO:** ***Zuckerman et al. 1990 (52)***	**YES:** No studies. **NO:** Sloan 1985 (38) ***Zuckerman et al. 1990 (52)*** Blackmon & Zeckhauser 1991 (4) Danzon et al. 2004 (10) ***Thorpe 2004 (43)***	**YES:** No studies. **NO:** Klick & Stratmann 2003 (24)
Pretrial screening panels	**YES:** No studies. **NO:** ***Danzon 1984 (8)*** ***Danzon 1986 (9)*** ***Sloan et al. 1989 (39)*** ***Zuckerman et al. 1990 (52)***	**YES:** No studies. **NO:** ***Danzon 1984 (8)*** ***Danzon 1986 (9)*** ***Zuckerman et al. 1990 (52)***	**YES :** Sloan 1985 (38) **NO:** ***Zuckerman et al. 1990 (52)***	No studies.
Periodic payment	**YES:** No studies. **NO:** ***Danzon 1984 (8)*** ***Sloan et al. 1989 (39)*** Blackmon & Zeckhauser 1991 (4)*	**YES:** No studies. **NO:** ***Danzon 1984 (8)***	**YES:** No studies. **NO:** Blackmon & Zeckhauser 1991 (4)	**YES:** No studies. **NO:** Klick & Stratmann 2003 (24)

† An earlier version of this table appeared in Studdert, 2004 (40). The 2005 study by Kessler et al. (23) is excluded because it grouped several reforms together, precluding the possibility of drawing inferences about the effects of particular reforms.

‡ Studies used different definitions of cap variable. Studies are classified as having significant findings if any specification of a damages cap variable was statistically significant.

* Study modeled insurer losses rather than average award size. Losses are a function of both average award and number of paid claims.

§ Some studies modeled mandatory and discretionary collateral offsets separately. Studies are classified as having significant findings if any specification of a collateral source offset variable was statistically significant.

¶ Study results were mixed.

The strongest studies are cited in bold print.

Findings

Good evidence shows that caps on damages reduce average award size by 20–30 percent, but there is no evidence that they decrease claims frequency. It is often argued that caps on damages will reduce claims frequency because claims with a lower potential value are less attractive to plaintiff's attorneys working on a contingent-fee basis. Proponents of caps see this as a benefit of caps, in that total litigation costs will likely be lower if fewer claims are filed. Opponents of caps see it as a problem, because it suggests that plaintiffs with meritorious claims might not have access to the courts. One controlled study found that there was no significant difference in frequency of claiming associated with caps on damages (52). The evidence base on this issue, however, consisting of only that one study, is insufficient for broad generalizations.

On the other hand, many studies have found that caps have a significant effect on claims payouts. Some studies have found that caps reduce total claims payouts or insurer losses (4, 49, 50) (see Appendix III). In the absence of evidence that caps reduce claims frequency, a reasonable inference is that the reduction is driven by lower average awards. Overall, caps appear to be associated with a 23 percent to 31 percent reduction in average awards. That caps reduce average awards should be uncontroversial because the literal effect of caps is to reduce awards. Of note, most of the evidence on this point comes from relatively old studies. It is possible that analysis of more recent data might yield a smaller effect on payouts, because increases in the costs of medical care may have led to growth over time in the economic component of malpractice awards as a proportion of the total award.

It is important to bear in mind that caps only apply to jury verdicts, although they may have a "shadow" effect on settlements. Less than ten percent of malpractice cases go to trial (48), and only some of these will result in a noneconomic damages award large enough to trigger the cap. A study of jury verdicts subject to the $250,000 cap in California found that 51 percent of the verdicts were reduced by the cap (42). An analysis of Missouri claims found that only six of 439 paid claims reached its cap, which was $557,000 in that year (25). Thus, caps formally touch only a fraction of all claims. Nevertheless, the effect on total award costs may be significant because caps affect the most costly claims.

The best studies suggest that caps are associated with a small increase in physician supply. Proponents of caps argue that they help states attract and retain physicians by providing relatively good insulation from malpractice judgments. Although it is insurers, and not physicians, who are responsible for paying large judgments, physicians as a group may feel the financial consequences over time in the form of higher insurance premiums. Until quite recently, however, there were no controlled studies evaluating the impact of caps on damages on the supply of physicians in a state.

Five studies, only two of which have been published in peer-reviewed publications, have examined the relationship between caps and physician supply using statistical methods to control for other state and local characteristics that may influence how attractive a particular state is to physicians. Of these, two studies have found that states with caps experience significantly higher growth in physician supply over time (20, 23), one found no significant effect (27) and two produced mixed results (13, 24). Some of the studies are methodologically stronger than others, so all should not be relied upon equally. The study with the strongest methodology found that "direct reforms" such as caps on damages were associated with three percent higher growth in physician supply over three years (23). The major shortcoming of this study is that it cannot separate out the effect of caps on damages from other "direct reforms" such as collateral-source rule reform. Overall, a reasonable conclusion to draw from this group of studies is that caps appear to be associated with a small but statistically significant increase in physician supply.

Findings

The most recent controlled studies show that caps moderately constrain the growth of premiums. A number of descriptive analyses by interest groups have linked caps with lower premiums. However, most of these studies are not very informative, because they do not control for other state characteristics that affect premiums, and suffer from other methodological problems (see Appendices II and III). Studies from earlier malpractice crises suggest that caps on noneconomic damages did not reduce malpractice premiums in the 1970s and 1980s. Four studies are available from that era; three had no significant findings (38, 50, 52) and the fourth had mixed findings (it also lumped caps on noneconomic damages together with caps on total damages and caps on punitive damages) (4).

In contrast, studies based on data from the 1990s and the early years of the current malpractice crisis consistently found that caps had a modest but statistically significant constraining effect on premiums during this period; the effect is on the order of a 6–13 percent reduction in the rate of growth (10, 22, 43, 49). It is not clear why study findings have differed across time periods. The more recent studies are the most useful because they best represent today's market conditions. Although they are not without limitations, most of these studies are of good quality and their overall findings can be considered reliable. Specific methodological strengths and limitations are described in Appendix III.

A few caveats are in order. First, most of the existing studies do not control very well for differences in the extent of regulation of insurance premium rates across states, which could be influential. The respective roles of rate regulation and caps on damages in constraining premium growth has been controversial, particularly in understanding the experience of California, which adopted both types of reforms (see Appendix IV).

Second, most of the studies do not indicate what level of noneconomic damages cap has the largest effect on premiums or claims; they tend to lump different levels of caps together. Third, caps on damages do not reduce premiums in absolute terms. Premiums have been rising over time (even after adjustment for inflation) even in states with caps; it is just that they have been rising more slowly in those states.

Finally, the effect of caps on premiums does not happen immediately. The studies indicate that some effects are typically experienced within a year, but the full effect does not manifest itself for three years. In summary, good evidence suggests that caps will have modest effects on the growth of insurance premiums over time; however, they will not prevent premium growth and they will not have large or immediate effects.

Caps on noneconomic damages have disadvantages relating to patient safety and equity in the medical liability system. When evaluating caps on damages as a policy solution, their impact on insurance costs is an important consideration, but so are two other considerations: deterrence and fairness. Opponents of caps are concerned that limiting liability will negatively affect patient safety because they will undermine the incentives for "deterrence"–that is, not practicing in a negligent manner. Some legal scholars respond by noting that there is very little evidence that the current medical liability system has much of a deterrent effect. It is probably the case that whatever modest deterrent effect does exist, however, is diminished by reforms, such as caps on damages, that make lawsuits less consequential for health care providers and insurers. The

more general argument that caps do not address the problem of patient safety in the health care system is compelling. The aim of caps is simply to limit liability; caps are not meant to reduce the incidence of medical error and adverse events, and there is no reason to think they do so.

Another objection that is often raised to caps on noneconomic damages is that they are unfair. The argument asserts that caps disproportionately affect plaintiffs who are severely injured, elderly, or female. Elderly and female plaintiffs may be especially burdened by caps, according to this argument, because they are relatively low wage-earners; therefore, the noneconomic component of their award tends to be proportionately larger than that of younger and male plaintiffs. Evidence from studies of jury verdicts that were subject to California's $250,000 cap on noneconomic damages shows that caps do indeed exacerbate existing inequities in compensation for medical injuries by disproportionately affecting the most severely injured plaintiffs (35, 42). The evidence that they disproportionately burden women or the elderly, however, is very limited (15, 35, 42).

In this malpractice crisis, a number of groups have expressed interest in alternative approaches to reform. The conventional reforms discussed so far, including caps on damages, have a limited goal: to reduce litigation costs, and thereby reduce malpractice insurance premiums. In a malpractice crisis, these are important goals. Many groups, however, have called for policymakers to consider more far-reaching reforms that would address other, more enduring problems with the medical liability system including its inefficiency, low rate of compensating injured patients, inequity in awarding compensation and lack of deterrence of medical errors.

Among the major alternative reform approaches now receiving attention are the following:

- *Schedules of Damages:* Some groups are considering whether it is possible to reap the advantages of caps on damages while avoiding the associated political difficulties and equity concerns by adopting a schedule of noneconomic damages. Schedules differ from flat caps in that they classify injuries into different severity tiers and then attach a range of dollar values to each tier, rather than imposing a single ceiling on pain-and-suffering awards. Juries are presented with the schedule and advised to use it as a guideline in reaching a decision about a noneconomic damages award. Because they would reduce insurers' uncertainty, particularly around very large judgments, damages schedules could help control the growth of insurance premiums. They also would help ensure that plaintiffs with similar injuries received similar noneconomic damages awards and that the size of the award increased with the severity of injury. To some, a significant disadvantage of damages schedules is that they limit the discretion of the jury in making decisions about compensation. They also may be less effective at cost control than a low-value flat cap.
- *Patient safety improvement:* Consumer groups and trial lawyers argue that the best way to reduce malpractice litigation costs is to reduce malpractice. If fewer medical errors were committed, they argue, there would be less litigation. They advocate implementation of clinical interventions that have been shown to be effective in reducing rates of adverse events–for example, the increased use of computerized physician order entry systems. The advantage of this approach is that, if successful, it would have the important dual benefit of providing relief to health care providers and improving the health and safety of patients. The problem is that epidemiological studies of medical injury show that there is a very poor correspondence between adverse events and malpractice claims. That is, most negligent medical injuries don't result in claims, and many injuries that aren't actually due to negligence do result in claims. As a result, even large decreases in rates of medical injuries should not be expected to decrease claims rates by very much (28).

Findings

- *Disclosure and "early offer" programs:* Studies suggest that two of the major reasons why people file malpractice suits are that they need compensation for their economic losses, such as lost wages, and that they are angry because they feel their doctor or hospital did not address their injury in a candid and compassionate way. Some reformers argue that these factors could be addressed by prompt and candid disclosure of adverse events accompanied by offers of reasonable compensation for economic losses. "Early offer" proposals typically specify that providers offer full compensation for past and future economic losses in exchange for the patient agreeing not to seek additional compensation for pain and suffering in a lawsuit. These proposals represent a promising avenue for resolving claims more quickly and at lower cost, particularly claims that are relatively straightforward. They could have the added benefit of preserving goodwill between the doctor, hospital and patient. Some lawyers object to such proposals because they fear that patients will be discouraged or barred from filing suit before they have had a chance to receive advice from a lawyer, who might explain that what is being offered by way of compensation is inadequate. They also object to the exclusion, in many proposals, of any compensation for noneconomic losses.
- *Demonstration projects of administrative compensation:* A number of groups are considering experimentation with pilot programs of administrative compensation, sometimes called "health courts." This model removes the adjudication of medical malpractice claims from courts and sets up an administrative process to evaluate claims instead.[5] The decision-making panel could be based at a hospital system, a liability insurer, or a state government agency. The panel would award compensation not just to patients injured by negligence, but to all patients whose injuries could have been avoided (a group that is larger than the group of injuries due to deviations from the standard of care). The panel would use decision guidelines to fast-track certain kinds of injuries for quick decisions based on the best available scientific evidence about their avoidability. These proposals show promise because they are simpler and more equitable but they are a tough sell politically in many jurisdictions. Administrative processes would be much more efficient than judicial decision-making, in part because neutral medical experts would replace costly battles between experts hired by the parties. Greater efficiency could result in considerable cost savings. Because a larger group of patients would be compensated under the expanded liability standard, however, the total costs of the system might not be lower.

[5] Administrative compensation proposals are different from arbitration programs. Arbitration uses the same compensation standard and similar procedures to the ordinary judicial process, but a different adjudicator. Administrative compensation involves not only a different adjudicator but also a different compensation standard and claiming process.

Implications for Policy-Makers

This Synthesis Report gives rise to a number of conclusions and policy implications.

First, **malpractice crises are likely to recur**. The U.S. has experienced three malpractice crises in the last thirty years, and none of the contributing conditions have changed or are likely to change. Thus, even though the malpractice insurance environment appears to be stabilizing in some states, it remains important and timely to consider appropriate policy responses to malpractice crises.

Second, **malpractice crises affect the supply and delivery of health care services, though the magnitude of the effect is sometimes overstated and difficult to measure.** Some of the claims that have been made about the effects of rising insurance costs during this malpractice crisis on patient care are probably exaggerated, but there is a modest effect on the supply of physicians. Malpractice crises also appear to be associated with heightened defensive-medicine behavior.

Third, **no single policy solution will address all of the factors that lead to malpractice crises**. The current malpractice crisis has multifaceted origins (which are discussed in more detail in the Primer in this series). Increased claims costs, imprudent insurer business decisions, decreased insurer investment returns, and other dynamics of the "insurance cycle" have all been contributing factors. Most policy strategies to address the crisis, such as caps on damages, have limited aims and impacts. They may be fairly effective at addressing one of the drivers, but not all of them. Some of the drivers, such as the insurance cycle, are temporary and essentially self-correcting. Policy-makers may prefer to let the market correct itself rather than intervene with tort reforms or insurance regulation. This strategy means that there will be good times and bad in the professional liability insurance market. Relying on the market would not necessarily preclude assistance for health care providers, such as premium subsidies or reimbursement increases, during periods of rapidly rising premiums.

Fourth, **caps on damages help constrain growth in litigation costs and insurance premiums over time, but disproportionately burden the most severely injured patients.** There is good evidence that caps reduce average award size and moderately constrain the growth of premiums. Most of their effect on premiums is seen over the medium term, not immediately. Caps have a small, albeit statistically significant, effect on physician supply. Fairness objections to caps on damages should be taken seriously, however. The evidence shows that rather than discouraging "frivolous" litigation, they disproportionately burden the most severely injured patients. There are probably less onerous ways to bring greater predictability and cost control to the liability system, such as damages schedules and programs that encourage early settlement.

Finally, **malpractice crises bring new attention to some of the fundamental problems with the medical liability system, which require more sweeping reform.** A compelling body of evidence establishes that the liability system performs poorly as a mechanism for directing compensation to injured patients in a thorough and equitable fashion, deterring medical error, and fostering an environment that supports patient safety initiatives such as adverse event reporting. Although they present more political challenges, reform proposals such as early-offer programs and health courts merit serious consideration and objective assessment.

The Need for Additional Information

Efforts should be made to improve the availability and quality of state data on claims and premiums. Efforts to evaluate the causes and consequences of the malpractice crisis have been frustrated by a lack of comprehensive, accessible data on malpractice claims and insurance premiums. This flows in part from the fact that malpractice law and insurance are matters of state law: there are few national databases and reporting requirements. Even within states, there is typically no systematic aggregation of data from individual trial courts, and departments of insurance vary in what they collect from individual insurance companies.

A recent report by the National Association of Insurance Commissioners recommended that state insurance regulators begin collecting comprehensive data on frequency of claims and average awards and major claim types represented, and maintain these data in a way that is useful for research purposes (32). Also needed are data on specialty-specific premium rates. Insurance commissioners are well situated to implement such reporting requirements, and the National Association of Insurance Commissioners could serve as a vehicle for standardizing reporting across states and combining reports into a multi-state database that could be made available, in de-identified form, to researchers.

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Appendix II Methodological Discussion

Methodological approach

The methodological approach for this synthesis was guided by its objective of educating policymakers about the differences between reliable and unreliable evidence concerning the causes and consequences of the malpractice crisis and potential solutions. We reviewed both high-quality studies and evidence of lesser quality; evaluated and distinguished them using accepted criteria of scientific rigor; and formulated our conclusions based on the best available evidence.

The criteria of scientific rigor that we applied included:

- Use of a data source that was sufficiently comprehensive to support the planned analyses
- Low potential for measurement error, nonrepresentativeness and other forms of bias in the data used
- Appropriateness of the analytical method chosen
- Adequacy of control for potentially confounding variables
- Adequacy of the sample size
- Appropriateness of the interpretation of data and conclusions drawn.

We comprehensively reviewed studies published in the academic literature, identifying candidate studies by searching PubMed, Westlaw, EconLit and online resources such as the Social Science Research Network and the National Bureau of Economic Research. We also identified studies by reviewing the lists of references cited in publications culled from those sources. We limited our review to studies from the mid-1980s forward.

Because the "grey literature"–unpublished reports and position papers–on the malpractice crisis is voluminous, our review is limited to analyses that have featured prominently in the policy debate at the national level. Our review included reports issued by or promoted or disseminated by the following influential organizations: the U.S. General Accountability Office, the Congressional Budget Office, the Office of the Assistant Secretary for Planning and Evaluation (U.S. Department of Health and Human Services), the American Medical Association, the American Trial Lawyers Association, the American Bar Association, Weiss Ratings, Inc., Tillinghast Towers-Perrin, Americans for Insurance Reform, the Center for Justice and Democracy, Public Citizen, the Foundation for Taxpayer and Consumer Rights, Milliman USA, Brown Brothers Harriman, the National Association of Insurance Commissioners, the Kaiser Family Foundation and the Physician Insurers Association of America.

Where the findings of well-designed studies conflicted with the findings of weaker studies, we aimed to explain why the findings of the weaker studies were less reliable. Where the findings of well-designed studies conflicted with one another, we identified methodological choices and issues (if any) that may explain the disparities. Where there was no scientific reason to place more credence in one set of findings than another, we characterized the state of knowledge about that point as one of ongoing uncertainty. In formulating conclusions that specifically relate to the current malpractice crisis, we placed more weight on evidence from recent studies than on studies from previous malpractice crises, since conditions in the insurance and health care markets may have changed over time.

Appendix II Methodological Discussion

Issues in measuring effects of malpractice environment on the supply of physician services

Claims about retirements, relocations, and restrictions on scope of practice could be investigated through several approaches, but each is problematic. First, physician self-reports can be collected. Several medical societies in crisis states, for example, have asked physicians to report their personal stories of having to leave or alter their medical practice. This sometimes produces large counts of affected physicians, but there is no way to know what percentage of affected physicians has offered their stories, how representative those stories are of physicians' experiences generally, or whether reporting physicians are providing all the relevant information.

Using an alternative approach, several medical societies and independent research studies have conducted physician surveys. One difficulty with these surveys, particularly those done by medical societies, is that they tend to have low response rates, in part because busy physicians are often reluctant to participate. Surveys with low response rates (under 60 percent) should be interpreted with caution; response rates of less than 45–50 percent should trigger great caution, particularly if the survey does not provide information on whether the people who responded differ significantly on some important characteristic from those who did not respond.

Surveys with higher response rates are more likely to provide representative data, but they still suffer from a potential response-bias problem. Physicians have a strong incentive to report that their increased insurance costs are affecting their ability to offer health services, because this builds the case for policy interventions. Many physician organizations have lobbied hard for reforms such as caps on damages, and individual physicians may feel a need to buttress their efforts. This may lead them to consciously or unconsciously exaggerate their responses. As well, surveys that elicit information on decisions that physicians plan to carry out in the future may not capture what physicians actually end up doing. Physicians may change their mind about retiring, for example, or may find it is impossible to establish a practice in another state. Thus, survey reports may tend to overestimate the effects of a malpractice crisis on the supply of physician services in a state.

An alternative methodology is to count physicians using datasets such as state licensure rolls or the American Medical Association Physician Masterfile, which compiles information on practicing physicians based on surveys and other data sources. Such datasets, however, have shortcomings. Licensure lists may not distinguish between physicians who are actively practicing full time and physicians who are inactive or who spend a large portion of their time on nonclinical activities. The Physician Masterfile is subject to reporting lags and is known to produce overestimates of physician supply and to have poor sensitivity in detecting physician retirements and relocations. Neither type of dataset captures shifts in the scope of practice within a clinical specialty.

This type of analysis also cannot provide information on the reasons physicians choose to retire, relocate, or stop offering some kinds of service. Similarly, simply counting the number of hospitals in crisis states that have stopped providing certain services may wrongly attribute some decisions to malpractice concerns. A 2003 investigation by the U.S. General Accounting Office of several reports of hospital service closures found support for some claims that these decisions were made because of liability costs, but found that there were other reasons that some of the facilities had closed (47). Overall, datasets on the number of providers could produce either an overestimate or an underestimate of the supply of services, and cannot causally link changes in the supply of services to malpractice insurance issues.

Appendix II Methodological Discussion

Finally, understanding the effects of a malpractice crisis on access to care is challenging because just knowing how many physicians stopped practicing in the state is not enough; one must also know something about how well-supplied the area was to begin with, and what the demand for services is. Even areas that lose a lot of physicians may not experience access-to-care problems if they were initially oversupplied. On the other hand, rural and other underserved areas may suffer greatly from the loss of even a single neurosurgeon.

Issues in measuring defensive medicine

Defensive medicine is often measured using physician surveys. Physicians may be asked general questions about the frequency of different behaviors, such as ordering unnecessary biopsies. Alternatively, they may be presented with hypothetical clinical scenarios and asked to say what they would do. General questions may be particularly susceptible to physicians' desire to give socially correct responses. Scenarios may elicit more concrete and genuine responses, but cannot easily elicit physicians' reasons for choosing different courses of action.

Studies comparing inter-state variation in rates of particular procedures that physicians might be inclined to order defensively can be powerful. However, because there are many factors that give rise to variation in the way medicine is practiced across geographic areas, it is critical that such studies adequately control for other state and local characteristics before inferring that variations are attributable to differences in the litigation and insurance environments.

Issues in measuring the effects of caps on damages

Simple descriptive studies purporting to establish the effects of caps on damages are much more prevalent than controlled studies. Descriptive data are problematic because there are many aspects of the legal, political, economic and insurance-market environments of states that affect claims frequency and award size, insurance premiums and physician supply. Comparisons of trends in litigation, premiums, or physician supply in different states are only valid if the states are similar in terms of other factors that are believed to affect these variables. The two major approaches taken to control for state characteristics are (1) to include variables representing each characteristic in the regression model; and (2) to use a model estimation method, such as difference-in-difference analysis, that implicitly controls for state characteristics by examining only the magnitude of change in the outcome variable for each state over time. Both are appropriate if done correctly.

Comparison groups may be inappropriate for the analysis. For example, one recent interest-group press release presented a bar chart comparing the average amount by which insurance premiums increased in 2003–2004 in "states recently passing damage caps" compared to "states without new damage caps" (1). It concluded that caps do not restrain premium growth because the average increase was much higher in the states that had recently adopted caps. But the comparison group evidently included both states without caps and states with older caps. The appropriate comparison would be to states without caps only–and then only after controlling for ways in which the capped and uncapped states differed.

Different kinds of caps may be lumped together in the analysis, making it difficult to determine which type is driving observed effects. In academic studies, different kinds of caps on noneconomic damages (for example, $250,000 flat caps and higher, inflation-adjusted caps) are often not distinguished in the analysis. In the grey literature, the blurring can be even worse: for example, in one widely cited report, the analysts grouped states with caps on

noneconomic damages together with states that capped total damages (34). A cap on total damages is a far more stringent type of cap, one not under serious consideration by any legislature today. The same report also failed to include one state that did have a noneconomic damages cap. The report concluded that states with caps had much more favorable insurer loss ratios than in the other states, but when the correct states are included in each group, the difference is much smaller.

Information on trends in premiums or claims payouts may be presented without adjusting for the number of physicians in the population. For example, one widely publicized graph compared "Premium Growth" in California versus the U.S. in general over the 1976-2000 period with no indication that what was actually reported was not per-capita physician premiums, but rather the total amount that insurers in California and the entire U.S. collected in physician premiums (33). Total premiums reflect not only the price of insurance but also the quantity of policies sold. We cannot tell if an increase in total premiums means that doctors are paying more for their insurance, or if the insurer is just selling more policies. If the number of physicians paying premiums in California changed at a different rate over time than the number of physicians paying premiums nationwide, the trendlines on this chart would give rise to a wrong inference about what physicians in different locations were paying. When the data underlying this graph are adjusted for the number of physicians, it becomes clear that: (1) the absolute difference between what a physician pays for insurance in California and what he pays elsewhere, on average, is not as large as a viewer of the graph would think; it's just a few hundred dollars; and (2) California did not do much better than the U.S. average over the study period, with the notable exception of the years running up to the current tort crisis (1998–2000).

Statistics on "average premiums" in a state are often based on a questionable use of company-specific premium data. The most widely cited source of premium data is the annual insurer survey conducted by the insurance industry newsletter The Medical Liability Monitor. This survey collects and reports company-specific premiums for three medical specialties for different regions of the state. The survey is a valuable data source, but it is not meant to support estimates of statewide average premiums, in part because not all companies participate in the survey. But a bigger issue is that most analyses compute a simple average premium for all the companies in the state without adjusting for the fact that the companies may have very different market shares. Computing a simple average, rather than a weighted average, treats the companies as though they have identical shares of the market. Adjusting for market share and also for the number of physicians insured in each region of the state can make a big difference in the estimate of statewide average premiums: for Kentucky in 2002, for example, the simple average premium for obstetrician-gynecologists was $58,287 but the weighted average premium was 19 percent less ($48,897) (51).

Data on trends in premiums, insurer losses, or average award size over time may not be adjusted for inflation. This leads to artificially steep trendlines, suggesting that increases in costs are larger than they were in real terms.

Appendix III Summary of Studies on Impact of Caps on Noneconomic Damages

Authors	Data Years	Findings	Methodological comments
Sloan et al. 1985 (38)	1974–1978	*Not significant.* Neither a cap on provider's liability nor a cap on plaintiff's recovery reduced premiums significantly.	Fairly strong analysis overall. *Strengths:* Uses per-capita premium data, rather than total premiums collected (which does not control for the number of physicians paying those premiums). Separately tests different kinds of caps. *Limitations:* Examines only short-term effect of caps passed in mid-1970s. Groups all types of caps together.
Danzon 1986 (9)	1975-1984	*Significant*: Having any kind of damages cap reduced the average **award size** by 23 percent.	Strong analysis overall. *Strengths:* Controls for six other tort reforms and many other factors that may affect average award size. *Limitations:* Data drawn from only eight insurers—may not be representative. Groups all types of caps together. Cannot examine long-term (post-1984) effect of caps.
Sloan et al. 1988 (39)	1975–1978, 1984	*Significant.* Average **award size** was 31 percent lower in states with caps on noneconomic damages than in uncapped states.	Strong analysis overall. *Strengths:* Controls for 19 other tort reforms. Separately tests different kinds of caps. *Limitations:* Potentially inadequate control for plaintiff characteristics that determine size of economic damages awards.
Zuckerman et al. 1990 (52)	1974–1986	*Not significant.* Neither a cap on noneconomic damages nor a cap on total physician liability reduced average **award size** or **claims frequency** significantly. **Premiums** in states with caps on noneconomic damages were no lower than in states without caps on noneconomic damages. (However, having a cap on total physician liability reduced premiums for general surgeons by an average of 13 percent in the year after adoption and 34 percent over the longer term.)	Very strong analysis overall. *Strengths:* Controls for a very wide range of confounding variables. Separately tests different kinds of caps. *Limitations:* Large number of variables included in the model may have adversely affected the statistical power of the model (its ability to detect significant effects).
Blackmon & Zeckhauser 1991 (4)	1985–1988	*Mixed.* In a model controlling for only four other kinds of tort reforms, having any kind of cap (whether on punitive or noneconomic damages) reduced **insurer losses** by 44 percent. However, in a model including a fuller range of other tort reforms, caps were not statistically significant.	Not a strong analysis overall. *Strengths:* Tests different model specifications to examine robustness of results. *Limitations:* Results in the restricted model are out of proportion to all other studies and not replicated in the more fully specified model. No control for state characteristics other than personal income growth. Cannot examine long-term effects of reforms passed in mid-1980s. Uses total rather than per-capita premium data. Groups together all kinds of caps.
Viscusi et al. 1993 (50)	1985-1988	*Not significant*. **Insurer losses** in states with any kind of noneconomic damages cap were not significantly lower. **Premiums** in states with any kind of damages cap were no lower than in uncapped states.	Not a strong analysis overall. *Strengths:* Separately tests different kinds of caps. *Limitations:* Incomplete controls for other tort reforms and inappropriate method of controlling for them. Uses total rather than per-capita premium data.
Kessler & McClellan 1997 (22)	1984-1993	*Significant.* Growth in self-reported **premiums** in states adopting "direct" tort reforms (either noneconomic or total damages cap, abolition of punitive damages, abolition of mandatory prejudgment interest, or collateral-source rule reform) was 8.4 percent lower at three years post-adoption. After one year, the effect size was 2.1 percent.	Fairly strong analysis overall. *Strengths:* Estimation method provides very strong control for state characteristics. *Limitations:* Groups together all kinds of caps, and groups caps with other tort reforms, so effect of noneconomic caps cannot be isolated. Uses self-reported rather than actual premium data.

† Table adapted from Michelle M. Mello and David M. Studdert, *Understanding Medical Malpractice Damages Caps*, working paper 2006.

Appendix III Summary of Studies on Impact of Caps on Noneconomic Damages

Authors	Data Years	Findings	Methodological comments
Klick & Stratmann 2003 (24)	1980-1998	*Mixed results.* Counterintuitively, $250,000 caps did not significantly affect **physician supply** but $500,000 caps did. States with the higher cap had three percent more doctors per 100,000 population than states without them.	Not a strong analysis overall. *Strengths:* Estimation method and model specification provide very strong control for state characteristics. Separately tests different levels of caps. *Limitations:* So many controls for state characteristics that model may be overspecified. Results are counterintuitive.
Hellinger & Encinosa 2003 (20)	1985-2000	*Significant.* States with caps have, on average, 12 percent higher physician supply per capita than states without caps, although physician supply has grown in both types of states.	Not a strong analysis overall. *Strengths:* Good controls for state characteristics other than tort reforms *Limitations:* Does not control for other tort reforms. Estimation method is not appropriate to the structure of the dataset. Groups together all kinds of caps.
Danzon et al. 2004 (10)	1994-2003	*Mixed.* Caps on noneconomic damages of $500,000 or lower were associated with six percent lower growth in **premiums**. Caps above that level did not significantly affect premiums.	Not a particularly strong analysis overall. *Strengths:* Separately tests different kinds of caps. Sophisticated estimation method. *Limitations:* Inappropriate averaging of company-specific premium data. Potentially overspecified model.
Matsa 2005 (27)	1970-2000	*Not significant.* The association between caps and overall physician supply was not significant, although caps did increase supply 10–12 percent from 1970 to 2000 for specialists in extremely rural areas.	Strong analysis overall. *Strengths:* Good controls for state characteristics including tort reforms. Sophisticated estimation method. *Limitations:* Groups together all kinds of caps.
Thorpe 2004 (43)	1985-2001	*Significant.* Having any kind of noneconomic damages cap reduced the growth of **premiums** by 12.7 percent.	Strong analysis overall. *Strengths:* Good controls for state characteristics including tort reforms. Models both total premiums and per-capita premiums. *Limitations:* Groups together all kinds of caps.
Viscusi & Born 2005 (49)	1984–1991	*Significant.* States with any kind of noneconomic damages cap had 16 percent lower **insurer losses** and 6.2 percent lower growth in **premiums** than uncapped states.	Not a particularly strong analysis overall. *Strengths:* Longitudinal analysis method captures change over time. Good controls for market factors affecting premiums and losses. Thorough sensitivity analyses confirm robustness of results. *Limitations:* Incomplete controls for other tort reforms. Groups together all kinds of caps. Uses total rather than per-capita premium data.
Encinosa & Hellinger 2005 (13)	1985-2000	*Mixed.* Counties subject to any damages cap (whether $250,000 or higher) had two percent higher **physician supply** per capita than counties without caps (three percent in rural counties); the difference was statistically significant. However, results not published in the paper showed, counterintuitively, that the $250,000 cap was not significant but the higher cap was.	Fairly strong analysis overall. *Strengths:* Good controls for state characteristics including tort reforms. Sensitivity analyses tested different levels of caps separately. *Limitations:* Unpublished results are counterintuitive, raising questions about the model.
Kessler et al. 2005 (23)	1985-2001	*Significant.* "Direct reforms" (e.g., caps on damages) are associated with three percent higher growth in **physician supply** after three years. The effect size varies by specialty, e.g., 12 percent difference for emergency medicine physicians but no significant difference for surgeons or radiologists. The effect is mainly due to retirements and entries rather than inter-state relocations.	Strong analysis overall. *Strengths:* Estimation method provides very strong control for state characteristics. *Limitations:* Groups together all kinds of caps, and groups caps with other tort reforms, so effect of noneconomic caps cannot be isolated.

† Table adapted from Michelle M. Mello and David M. Studdert, *Understanding Medical Malpractice Damages Caps*, working paper 2006.

Appendix IV California Case Study

Tort-reform advocates point to California's Medical Injury Compensation Reform Act (MICRA) as proof that caps on noneconomic damages can combat volatility in professional liability insurance premiums. MICRA was a package of tort reforms that included a non-inflation-adjusted limit of $250,000 on noneconomic damages. MICRA was passed in 1975, but legal challenges to its constitutionality were not settled until 1985. Opponents of MICRA-style reforms argue that California's lower premium growth is due not to MICRA, but to an insurance reform package known as Proposition 103 (Cal. Ins. Code §§ 1861.01–.16), approved by California voters on November 8, 1988. The most important features affecting professional liability insurance were (1) a requirement that insurers immediately roll back their rates by 20 percent; and (2) a requirement that insurers submit proposed changes in their rates for prior approval by the state insurance commissioner after November 8, 1989.

Evaluating competing claims about MICRA and Prop. 103 is challenging; no rigorous studies of its effects on malpractice premiums have been undertaken. There is a temporal correlation between the passage of Prop. 103 and the leveling off of malpractice premiums in California around 1988–1989; however, it is difficult to infer a casual relationship because of two potentially confounding factors. First, legal challenges to MICRA were settled shortly before then, and one would expect the full effect of MICRA to manifest itself at that time. Second, the malpractice crisis of the mid-1980s started to abate around this time in many states across the country. One way of analyzing the effect of Prop. 103 is to examine how the specific regulatory provisions actually played out. California is not the only state to adopt a prior-approval requirement; about a dozen states have such a rule. A handful of academic studies have analyzed the influence of rate-regulation regimes on malpractice premiums and most have not found prior approval to be a significant predictor, although one well-designed, controlled study did find that prior-approval states had lower premiums in the late 1970s and early 1980s (52).

The effect of a prior-approval rule may vary depending on how stringently the insurance commissioner exercises his discretion to disapprove proposed rate changes. Data from the California Department of Insurance on closed rate filings show that in 2000–2003, the Department received 59 medical malpractice insurer requests for rate increases (not including requests from insurers that handled only dentists or podiatrists). Excluding five cases in which the insurer withdrew the request, the Department approved the full increase or close to the full increase requested 89 percent of the time. The median premium increase approved was 11 percent and the largest was 80 percent. The Department received eight requests for rate decreases and fully approved all of them. These findings suggest that during the period of the malpractice crisis, the prior-approval rule has infrequently prevented insurers in California from receiving requested rate increases. It is possible that it deterred some from requesting increases.

What about the 20 percent rollback? In the early years of Prop. 103, three malpractice insurers reportedly returned over $89 million to physicians due to the rollback. However, in 1994, the California courts held that the automatic 20 percent rollback provision was unconstitutional because it could deprive insurers of a fair rate of return. Subsequently, the insurance commissioner softened the provision: insurers would only have to reduce premiums insofar as their rate of return exceeded a "fair" rate of 10 percent. Thus, Prop. 103 has effected some rebates of malpractice premiums, but they have not been as large as voters intended.

In summary, the uniqueness of Prop. 103's particular combination of insurance reforms, and the fact that its adoption coincided with a significant shift in the malpractice insurance environment nationwide, makes it difficult to rigorously test its effect on malpractice premiums. It seems likely that both Prop. 103 and MICRA have played a role in controlling the growth of premiums in California.

Notes

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SPECIAL ARTICLE

Claims, Errors, and Compensation Payments in Medical Malpractice Litigation

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ABSTRACT

BACKGROUND

In the current debate over tort reform, critics of the medical malpractice system charge that frivolous litigation — claims that lack evidence of injury, substandard care, or both — is common and costly.

METHODS

Trained physicians reviewed a random sample of 1452 closed malpractice claims from five liability insurers to determine whether a medical injury had occurred and, if so, whether it was due to medical error. We analyzed the prevalence, characteristics, litigation outcomes, and costs of claims that lacked evidence of error.

RESULTS

For 3 percent of the claims, there were no verifiable medical injuries, and 37 percent did not involve errors. Most of the claims that were not associated with errors (370 of 515 [72 percent]) or injuries (31 of 37 [84 percent]) did not result in compensation; most that involved injuries due to error did (653 of 889 [73 percent]). Payment of claims not involving errors occurred less frequently than did the converse form of inaccuracy — nonpayment of claims associated with errors. When claims not involving errors were compensated, payments were significantly lower on average than were payments for claims involving errors ($313,205 vs. $521,560, P=0.004). Overall, claims not involving errors accounted for 13 to 16 percent of the system's total monetary costs. For every dollar spent on compensation, 54 cents went to administrative expenses (including those involving lawyers, experts, and courts). Claims involving errors accounted for 78 percent of total administrative costs.

CONCLUSIONS

Claims that lack evidence of error are not uncommon, but most are denied compensation. The vast majority of expenditures go toward litigation over errors and payment of them. The overhead costs of malpractice litigation are exorbitant.

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THE DEBATE OVER MEDICAL MALPRACTICE litigation continues unabated in the United States[1] and other countries.[2-4] Advocates of tort reform, including members of the Bush administration, lament the burden of "frivolous" malpractice lawsuits and cite them as a driving force behind rising health care costs.[5,6] (A frivolous claim is one that "present[s] no rational argument based upon the evidence or law in support of the claim."[7]) Plaintiffs' attorneys refute this charge, countering that contingency fees and the prevalence of medical errors make the pursuit of meritless lawsuits bad business and unnecessary.[8,9]

Previous research has established that the great majority of patients who sustain a medical injury as a result of negligence do not sue.[10,11] However, the merit of claims that are brought, and the ability of the malpractice system to resolve them appropriately, remain much more controversial.[1,12-14] If frivolous claims are common and costly, they may be a substantial source of waste in the health care and legal systems.

We investigated the merits and outcomes of malpractice litigation using structured retrospective reviews of 1452 closed claims. The reviews included independent assessments of whether the claim involved injury due to medical error. Our aim was to measure the prevalence, costs, outcomes, and distinguishing characteristics of claims that did not involve identifiable error.

METHODS

STUDY SITES

Five malpractice insurance companies in four regions of the United States (the Northeast, Mid-Atlantic, Southwest, and West) participated in the study. Collectively they covered approximately 33,000 physicians, 61 acute care hospitals (35 of them academic and 26 nonacademic), and 428 outpatient facilities. The study was approved by ethics review boards at the investigators' institutions and at each review site (i.e., the insurer or insured entity).

CLAIMS SAMPLE

Data were extracted from random samples of closed-claim files at each insurance company. The claim file is the repository of information accumulated by the insurer during the life of a claim (see the Supplementary Appendix, available with the full text of this article at www.nejm.org). We also obtained the relevant medical records from insured institutions for all claims included in the sample.

Following the methods used in previous studies, we defined a claim as a written demand for compensation for medical injury.[15,16] Anticipated claims or queries that fell short of actual demands did not qualify. We focused on four clinical categories — obstetrics, surgery, missed or delayed diagnosis, and medication — and applied a uniform definition of each at all sites. These are key clinical areas of concern in research on patient safety; they are also areas of paramount importance to risk managers and liability insurers, accounting for approximately 80 percent of all claims in the United States and an even larger proportion of total indemnity costs.[17-19]

Insurers contributed claims to the study sample in proportion to their annual volume of claims. The number of claims by site varied from 84 to 662 (median, 294). One site contributed obstetrics claims only; another site had claims in all categories except obstetrics; and the remaining three contributed claims from all four categories.

REVIEW OF CLAIM FILES

Reviews were conducted at insurers' offices or insured facilities by board-certified physicians, fellows, or final-year residents in surgery (for surgery claims), obstetrics (for obstetrics claims), and internal medicine (for diagnosis and medication claims). Physician investigators from the relevant specialties trained the reviewers, in one-day sessions at each site, with regard to the content of claims files, use of the study instruments, and confidentiality procedures. Reviewers were also given a detailed manual. Reviews lasted 1.6 hours per file on average and were conducted by one reviewer. To test the reliability of the process, 10 percent of the files were reviewed again by a second reviewer who was unaware of the first review.

Staff members at the insurance companies recorded administrative details of each claim, and clinical reviewers recorded details of the patient's adverse outcome, if any. Physician reviewers then scored adverse outcomes on a severity scale that ranged from emotional injury to death.[20] If there was no identifiable adverse outcome, the review

was terminated. For all other claims, reviewers considered the potential contributory role of 17 "human factors" in causing the adverse outcome.

Next, in the light of all available information and their decisions about contributing factors, reviewers judged whether the adverse outcome was due to medical error. We used the definition of error of the Institute of Medicine: "the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning)."[21] Reviewers recorded their judgments using a 6-point confidence scale in which a score of 1 indicated little or no evidence that an adverse outcome resulted from one or more errors and a score of 6 indicated virtually certain evidence that an adverse outcome resulted from one or more errors. Claims that received a score of 4 ("more likely than not that adverse outcome resulted from error or errors; more than 50–50 but a close call") or higher were classified as involving an error.

Reviewers were not blinded to the outcome of litigation because it was logistically impossible to censor this information in the files. However, they were instructed to ignore this outcome and exercise independent clinical judgment in rendering determinations with regard to injury and error. Training sessions stressed both that the study definition of error is not synonymous with the legal definition of negligence and that a mix of factors extrinsic to merit influences whether claims are paid during litigation.

STATISTICAL ANALYSIS

The data forms, which had been filled out by hand, were electronically entered into a database and verified by a professional data-entry vendor and then sent to the Harvard School of Public Health in Boston for analysis. Analyses were conducted with the use of the SAS 8.2 and Stata SE 8.0 statistical software packages. To compare characteristics of claims with and claims without errors, we used Fisher's exact tests (for analyses involving the sex of the plaintiff, specialty of the defendant, severity of injury, type of claim, and litigation outcomes), t-tests (for analyses involving the age of the plaintiff and filing and closure periods), and Wilcoxon rank-sum tests (for analyses involving indemnity and defense costs). All reported P values are two-sided.

The total cost of claims in the sample was calculated and apportioned between claims with and those without errors. The analysis addressed the direct costs of the litigation, not the indirect costs, such as those associated with the practice of defensive medicine.[22] We refer to the patient who allegedly sustained injury as the plaintiff, even though some claims were brought by third parties. We used kappa scores to measure the reliability of the determinations of injury and error.[23]

RESULTS

CHARACTERISTICS OF THE PLAINTIFFS

Sixty percent of the plaintiffs were female (Table 1). The median age of the plaintiffs was 38 years; 19 percent were newborns, and 12 percent were 65 years of age or older. Obstetrician-gynecologists were the most frequently sued physicians in the sample (19 percent), followed by general surgeons (17 percent) and primary care physicians (16 percent).

In 37 of the claims (3 percent), no adverse outcome from medical care was evident. For example, one claim alleged that substandard care had caused the plaintiff to acquire methicillin-resistant *Staphylococcus aureus*, but there was no evidence of infection in the medical record or claim file. An additional 52 claims (4 percent) involved psychological or emotional injury, and 9 (<1 percent) contained only allegations of breaches of informed consent. The remaining claims involved physical injury, which was typically severe. Eighty percent of claims involved injuries that caused significant or major disability (39 percent and 15 percent, respectively) or death (26 percent).

Eighty-three percent of the claims were closed between 1995 and 2004; 62 percent were closed in 1998 or later. The average length of time between the occurrence of the injury and the closure of the claim was five years.

Fifty-six percent of the claims received compensation, at an average of $485,348 (median, $206,400) per paid claim. Fifteen percent of the claims were decided by trial verdict. The awards in verdicts for the plaintiff on average were nearly twice the size of payments made outside of court ($799,365 vs. $462,099). However, plaintiffs rarely won damages at trial, prevailing in only 21 percent of verdicts as compared with 61 percent of claims resolved out of court. Administrative (or overhead) costs associated with defending the

Table 1. Characteristics of Litigants, Injuries, and 1452 Claims.

Characteristic	
Plaintiffs	
Female — no. (%)*	844 (60)
Age — no. (%)	
<1 yr	271 (19)
1–17 yr	82 (6)
18–34 yr	267 (18)
35–49 yr	383 (26)
50–64 yr	281 (19)
≥65 yr	168 (12)
Health insurance — no. (%)*	
Private	592 (68)
Medicaid	88 (10)
Uninsured	81 (9)
Medicare	73 (8)
Other	31 (4)
Defendants	
Physicians per specialty — no. (%)	
Obstetrics-gynecology	276 (19)
General surgery	242 (17)
Primary care	236 (16)
Orthopedic surgery	110 (8)
Neurosurgery	71 (5)
Radiology	66 (5)
Anesthesiology	65 (4)
Emergency medicine	55 (4)
Pediatrics	51 (4)
Nurses — no. (%)†	124 (9)
Trainees — no. (%)	430 (30)
Residents	391 (27)
Fellows	55 (4)
Interns	27 (2)
Facility codefendants — no. (%)	933 (64)
Hospital	712 (49)
Office or practice	328 (23)
Outpatient clinic	69 (5)
Ambulatory surgical department	24 (2)
Injuries	
Severity — no. (%)	
No injury	37 (3)
Breach of informed consent	9 (<1)
Psychological or emotional injury	52 (4)
Minor physical injury	187 (13)
Significant physical injury	573 (39)
Major physical injury	220 (15)
Death	374 (26)

Characteristic	
Injuries (continued)	
Location — no. (%)	
Inpatient	827 (57)
Outpatient	625 (43)
Claims	
Closure date — no. (%)	
1984–1989	57 (4)
1990–1994	190 (13)
1995–1999	542 (37)
2000–2004	663 (46)
Type — no. (%)	
Surgery	444 (31)
Obstetrics	335 (23)
Missed or delayed diagnosis	429 (30)
Medication	244 (17)
Claims resolved by trial verdict — no. (%)‡	215 (15)
Claims with compensation paid — no. (%)	811 (56)
Out of court	766 (61)¶
Verdicts for plaintiffs	45 (21)¶
Amount of compensation paid — $§‖	
Mean	485,348
Median	206,400
Out of court	
Mean	462,099
Median	196,688
Verdicts for plaintiffs	
Mean	799,365
Median	290,000
Defense costs — $§	
Mean	52,521
Median	27,954
Out of court	
Mean	42,015
Median	22,994
Verdicts for patients	
Mean	112,968
Median	89,484
Time from injury to closure — yr	
Mean	5
Median	4
Injury to filing of claim	
Mean	2
Median	1
Opening to closure of claim	
Mean	3
Median	3

* Percentages were calculated with the number of available observations used as the denominator. Data regarding sex were missing in 35 claims (2 percent), 25 of which involved injuries to infants. Data regarding the type of health insurance were missing in 587 claims (40 percent). For patients with multiple sources of health insurance, reviewers were asked to select a primary insurer.

† Nurses included 89 registered nurses, 39 advanced-practice nurses, and 4 licensed practical nurses. Some claims involved more than one type of nurse.

‡ The verdict was for the plaintiff or the defendant.

§ Values are given in 2004 dollars.

¶ Percentages were calculated within subcategories (out-of-court resolutions and verdicts, respectively).

‖ Compensation amounts were calculated on the basis of paid claims only.

claims averaged $52,521 per claim, with the mean administrative costs for claims that were resolved by trial ($112,968) nearly three times those for claims resolved out of court ($42,015).

RELATIONSHIP BETWEEN ERROR AND COMPENSATION

Sixty-three percent of the injuries were judged to be the result of error (Fig. 1). Most claims involv-

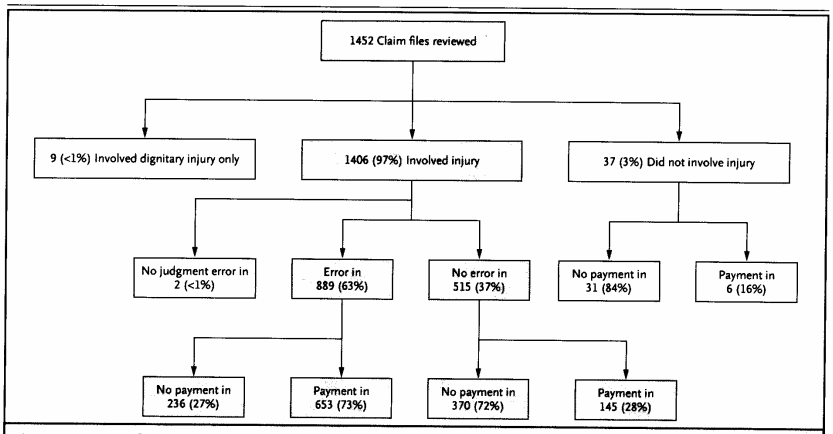

Figure 1. Overview of the Relationship among Claims, Injuries, Errors, and Outcomes of Litigation.
For claims classified as involving dignitary injury only, a breach of informed consent was the only injury alleged in the claim. Five of these claims resulted in payment.

ing injuries due to error received compensation (653 of 889 [73 percent]), and most claims that did not involve errors (370 of 515 [72 percent]) or injuries (31 of 37 [84 percent]) did not. Overall, 73 percent (1054 of 1441) of all claims for which determinations of merit were made had outcomes concordant with their merit. Discordant outcomes in the remaining 27 percent of claims consisted of three types: payment in the absence of documented injury (6 of 1441 [0.4 percent of all claims]), payment in the absence of error (10 percent), and no payment in the presence of error (16 percent). Thus, nonpayment of claims with merit occurred more frequently than did payment of claims that were not associated with errors or injuries. All results hereafter relate to the subsample of 1404 claims that involved injuries and for which determinations of error were made.

CONFIDENCE IN JUDGMENTS REGARDING ERROR

Reviewers had a high level of confidence in the determination of error in 44 percent of claims (those receiving scores of 1 or 6) and a moderate level of confidence in 30 percent (those receiving scores of 2 or 5); the remaining 23 percent were deemed "close calls" (Fig. 2). More than half the claims that were classified as not involving error had little or no evidence of error. The probability of payment increased monotonically with reviewers' confidence that an error had occurred.

CHARACTERISTICS OF CLAIMS NOT INVOLVING ERROR

With respect to characteristics of the litigant, severity of the injury, and type of claim, there were few differences between claims that did not involve error and those that did (Table 2). However, the outcomes of litigation among claims not associated with error (non-error claims) and those associated with error (error claims) differed significantly. Non-error claims were more likely to reach trial than were error claims (23 percent vs. 10 percent, $P<0.001$). Non-error claims were also much less likely to result in compensation, whether they were resolved out of court (34 percent vs. 77 percent, $P<0.001$) or by verdict (9 percent vs. 43 percent, $P<0.001$). In addition, when non-error claims were paid, compensation was significantly lower on average ($313,205 vs. $521,560, $P=0.004$).

TOTAL EXPENDITURES

The claims in the study sample cost more than $449 million, with total indemnity costs of more than $376 million and defense costs of almost

$73 million (Table 3). Non-error claims accounted for 16 percent of total system costs, 12 percent of indemnity costs, and 21 percent of administrative costs. With the exclusion of the 85 claims in which the reviewers' judgment that the claim did not involve error was a close call, non-error claims accounted for 13 percent of total expenditures.

RELIABILITY AND SENSITIVITY ANALYSES

Reliability testing was performed on the basis of 148 pairs of reviews. Kappa scores were 0.78 (95 percent confidence interval, 0.65 to 0.90) for the determination of injury and 0.63 (95 percent confidence interval, 0.12 to 0.74) for the judgment that error occurred, but scores for the latter varied across the clinical categories (surgery, 0.80; medication, 0.76; obstetrics, 0.56; and diagnosis, 0.42).

The exclusion of claims in which the primary reviewer classified the determination of error as a close call substantially boosted the overall reliability (kappa score, 0.80; 95 percent confidence interval, 0.32 to 0.88) and category-specific reliability (surgery, 0.94; medication, 0.90; obstetrics, 0.67; diagnosis, 0.63) of the error judgments. In this smaller sample of claims, the proportion that did not involve error increased slightly, to 40 percent (430 of 1065), and changes with regard to the magnitude and significance of the various differences between the two types of claims (as shown in Table 2) were trivial. Our main findings were also robust when a sensitivity analysis was performed that excluded the obstetrics claims and diagnosis claims, the two clinical categories with the lowest levels of reliability.

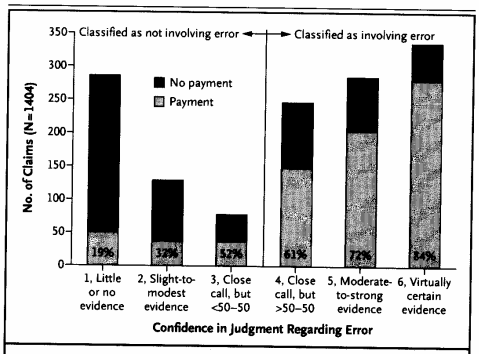

Figure 2. Determinations of Error According to Confidence Level and Payment Status.

The 1404 claims exclude the 9 that were associated with dignitary injuries only, the 37 with no injuries, and the 2 for which no judgments regarding error were made.

DISCUSSION

We found that only a small fraction of claims lacked documented injuries. However, approximately one third of claims were without merit in the sense that the alleged adverse outcomes were not attributable to error. Claims without merit were generally resolved appropriately: only one in four resulted in payment. When close calls were excluded, claims without evidence of injury or error accounted for 13 percent of total litigation costs.

Several previous studies have investigated the relationship between the merits and outcomes of malpractice claims.[24-30] The findings vary widely, with 40 to 80 percent of claims judged to lack merit and 16 to 59 percent of claims without merit receiving payment. Each of the studies also has important weaknesses: they involved the use of small numbers of claims[27,29]; they focused on a single hospital,[28] insurer,[25] specialty,[24,30] or type of injury[27]; they involved the use of very limited information in the determination of merit[26]; or they relied on the insurer's view of the defensibility of the claim as a proxy for merit rather than on independent expert judgments.[25,28,30] Our study was designed to avoid these limitations. Cheney and colleagues analyzed 1004 claims involving the use of anesthesia that were closed at 17 insurers in the 1970s and 1980s and found that approximately 40 percent of the claims did not involve substandard care, of which 42 percent received payment.[24] We detected a similar proportion of claims that did not involve error, but much fewer of them resulted in compensation.

We found stark differences in the outcomes of litigation for claims that did and those that did not involve errors: non-error claims were more than twice as likely as error claims to go to trial; they were nearly one third as likely to result in compensation; and when the plaintiffs received compensation, payments averaged 60 percent of the amount paid for error claims. Otherwise, non-error claims had few distinguishing characteristics. Economic theories regarding litigants' behavior[31] suggest that two characteristics will

Table 2. Characteristics of Claims Involving Error and Those Not Involving Error.

Characteristic	Claim		P Value
	Error (N=889)	No Error (N=515)	
Litigants			
Female plaintiff — no. (%)*	526 (61)	295 (58)	0.39
Mean age of plaintiff — yr	35.4	36.4	0.43
Physician specialty — no. (%)†			
Ophthalmology	7 (1)	13 (3)	0.02
Neurosurgery	50 (6)	16 (3)	0.04
Urology	15 (2)	25 (5)	0.001
Nurse — no. (%)‡	89 (10)	35 (7)	0.04
Facility codefendant — no. (%)	590 (66)	313 (61)	0.04
Severity of injury — no. (%)			
Psychological or emotional	25 (3)	26 (5)	0.04
Minor physical	106 (12)	81 (16)	0.05
Significant physical	372 (42)	201 (39)	0.31
Major physical	147 (17)	72 (14)	0.22
Death	239 (27)	135 (26)	0.80
Type of claim — no. (%)			
Surgery	258 (29)	163 (32)	0.30
Obstetrics	209 (24)	123 (24)	0.90
Missed or delayed diagnosis	259 (29)	155 (30)	0.72
Medication	163 (18)	74 (14)	0.06
Outcome of litigation			
Resolved by verdict — no. (%)	91 (10)	117 (23)	<0.001
Indemnity paid — no. (%)	653 (73)	145 (28)	<0.001
Out of court — no. (%)§	614 (77)	134 (34)	<0.001
By verdict — no. (%)§	39 (43)	11 (9)	<0.001
Mean payment levels — $			
All payments§	521,560	313,205	0.004
Verdicts for plaintiffs§	765,486	326,009	0.24
Other			
Mean defense costs (all claims) — $	50,966	55,233	0.50
Mean time from injury to filing of claim — yr	1.6	2.2	<0.001

* Percentages were calculated with the use of available data (507 claims not involving error and 869 involving error).
† Only significant subcategories are shown.
‡ This category includes registered nurses, advanced-practice nurses, and licensed practical nurses.
§ Percentages were calculated within subcategories.

mark such claims: close calls in terms of whether an error has occurred and relatively serious injury. Neither characteristic was borne out in our analyses. The profile of non-error claims we observed does not square with the notion of opportunistic trial lawyers pursuing questionable lawsuits in circumstances in which their chances of winning are reasonable and prospective returns in the event of a win are high. Rather, our findings underscore how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and shar-

Table 3. Apportionment of Total Expenditures between Claims Involving Error and Those Not Involving Error.

Costs	All Claims (N=1441)*	Claims Involving Error	Claims Involving No Error	Claims Involving No Error, Excluding Close Calls†
	$		*percent*	
Total system‡	449,090,663	84	16	13
Indemnity	376,473,069	88	12	9
Administrative	204,383,168	78	21	20
Defense	72,617,594	61	39	48
Plaintiff§	131,765,574	88	12	9

* The total number of claims excludes 11 for which judgments regarding neither injury nor error were available.
† The 85 excluded claims were those for which the reviewer recorded a confidence score of 3 ("less likely than not that adverse outcome resulted from error or errors; more than 50–50 but a close call").
‡ Total system costs are the sum of indemnity costs and defense administrative costs. Including plaintiff administrative costs in the sum would result in double counting because these form a percentage of indemnity costs.
§ Plaintiff administrative costs are estimated on the basis of a contingency fee of 35 percent on indemnity payments.

ing of information that litigation triggers. Previous research has described tort litigation as a process in which information is cumulatively acquired.[32]

Our findings point toward two general conclusions. One is that portraits of a malpractice system that is stricken with frivolous litigation are overblown. Although one third of the claims we examined did not involve errors, most of these went unpaid. The costs of defending against them were not trivial. Nevertheless, eliminating the claims that did not involve errors would have decreased the direct system costs by no more than 13 percent (excluding close calls) to 16 percent (including close calls). In other words, disputing and paying for errors account for the lion's share of malpractice costs. A second conclusion is that the malpractice system performs reasonably well in its function of separating claims without merit from those with merit and compensating the latter. In a sense, our findings lend support to this view: three quarters of the litigation outcomes were concordant with the merits of the claim.

However, both of these general conclusions obscure several troubling aspects of the system's performance. Although the number of claims without merit that resulted in compensation was fairly small, the converse form of inaccuracy — claims associated with error and injury that did not result in compensation — was substantially more common. One in six claims involved errors and received no payment. The plaintiffs behind such unrequited claims must shoulder the substantial economic and noneconomic burdens that flow from preventable injury.[33,34] Moreover, failure to pay claims involving error adds to a larger phenomenon of underpayment generated by the vast number of negligent injuries that never surface as claims.[10,11]

In addition, enthusiasm about the precision of the malpractice system must be tempered by recognition of its costs. Among the claims we examined, the average time between injury and resolution was five years, and one in three claims took six years or more to resolve. These are long periods for plaintiffs to await decisions about compensation and for defendants to endure the uncertainty, acrimony, and time away from patient care that litigation entails.

In monetary terms, the system's overhead costs are exorbitant. The combination of defense costs and standard contingency fees charged by plaintiffs' attorneys (35 percent of the indemnity payment) brought the total costs of litigating the claims in our sample to 54 percent of the compensation paid to plaintiffs. The fact that nearly 80 percent of these administrative expenses were absorbed in the resolution of claims that involved harmful errors suggests that moves to combat frivolous litigation will have a limited effect on total costs. Substantial savings depend on reforms that improve the system's efficiency in the handling of reasonable claims for compensation.

Our study has four main limitations. First, the sample was drawn from insurers and involved clinical categories that are not representative of malpractice claims nationwide. Academic institutions and the physicians who staff them were over-

represented, as were claims that fell within our clinical categories of interest. Although it is difficult to make comparisons with other samples of closed claims, both the proportion of claims receiving payments and the average amount of the payments appear to be high according to national standards, which probably reflects the preponderance of severe injuries in our sample.

Second, the reliability of judgments that error had occurred was moderate overall; agreement was especially difficult to obtain among claims involving missed or delayed diagnoses. Third, whether claims had merit was determined by reference to error, which is not identical to the legal concept of negligence, although the two cleave so closely that experts in both medicine and law have trouble explaining the difference. Fourth, reviewers' awareness of the litigation outcome may have biased them toward finding errors in claims that resulted in compensation, and vice versa.[35,36] To the extent that such hindsight bias was a factor, its likely effect would be to pull the rate of non-error claims (37 percent) toward the payment rate (56 percent), resulting in an overestimate of the prevalence and costs of claims not associated with error.

Frivolous litigation is in the bull's-eye of the current tort-reform efforts of state and federal legislators. The need to constrain the number and costs of frivolous lawsuits is touted as one of the primary justifications for such popular reforms as limits on attorneys' fees, caps on damages, panels for screening claims, and expert precertification requirements. Our findings suggest that moves to curb frivolous litigation, if successful, will have a relatively limited effect on the caseload and costs of litigation. The vast majority of resources go toward resolving and paying claims that involve errors. A higher-value target for reform than discouraging claims that do not belong in the system would be streamlining the processing of claims that do belong.

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