S. HRG. 109–710

MEDICAL LIABILITY: NEW IDEAS FOR MAKING THE SYSTEM WORK BETTER FOR PATIENTS

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

ON

EXAMINING ALTERNATIVES TO IMPROVE THE MEDICAL LIABILITY SYSTEM TO WORK BETTER FOR PATIENTS, FOCUSING ON S. 1337, TO RESTORE FAIRNESS AND RELIABILITY TO THE MEDICAL JUSTICE SYSTEM AND PROMOTE PATIENT SAFETY BY FOSTERING ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION

JUNE 22, 2006

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MEDICAL LIABILITY: NEW IDEAS FOR MAKING THE SYSTEM WORK BETTER FOR PATIENTS

THURSDAY, JUNE 22, 2006

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10:02 a.m., in Room SD–430, Dirksen Senate Office, Hon. Michael B. Enzi, chairman of the committee, presiding.

Present: Senators Enzi, Hatch, and Kennedy.

OPENING STATEMENT OF SENATOR ENZI

The CHAIRMAN. Good morning, and thank you for coming to this hearing of the Senate Committee on Health, Education, Labor, and Pensions. I appreciate the time our witnesses have taken to be with us and to be a part of this important discussion.

Today, we'll be focusing on our medical liability system and looking at new ideas for making the system work better for patients. We are looking to our witnesses for suggestions, good ideas, and observations based upon experience of how to make our medical liability system more efficient and effective for everyone involved.

As you know, Senator Baucus and I have introduced a bill to encourage and support State efforts to develop new ideas for resolving disputes over medical errors. Senator Clinton has also introduced a bill, and Senator Cornyn is working on one as well. I'm sure I speak for all of us when I say, we welcome your thoughts on those bills today. There's no doubt that we need a medical justice system that delivers quick and fair compensation to injured patients. But it must also provide consistent and reliable results so that doctors can eliminate the practice of overly defensive medicine and learn from the medical errors of colleagues.

Right now, our system fails to deliver on either of these goals. Earlier this year, when the Senate debated legislation to provide flexible caps on noneconomic damages, I noticed something interesting: no one stood up to defend our current system of medical litigation. In fact, even the lawyers in this body agreed that our medical litigation system is broken and needs to be fixed.

Now, why didn't we hear anyone defend the merits of our current medical litigation system? It's because everyone knows our current system doesn't work like it should. It doesn't work for patients, and it doesn't work for healthcare providers. Under our current medical litigation system, many patients who are hurt by negligent actions

receive no compensation for their loss. Those who do receive compensation end up with only about 40 cents of every premium dollar after legal fees and other costs are subtracted.

Outcomes of litigation may not bear relation to whether a healthcare provider was at fault. Therefore, our current litigation system masks underlying medical errors. Consequently, we are not learning from our mistakes. It seems clear that the medical litigation system can and must be improved so that we can learn from the medical errors that occur and use that knowledge to improve our delivery system.

Any new and improved medical litigation system should not encourage the wasteful use of medical resources. It must compensate injured patients in a fast and fair fashion. It should keep more doctors in the operating and emergency room, not testifying in the courtroom. When someone has a medical emergency, they want to see a doctor, not a lawyer. Everyone on this committee, I think, shares these important goals.

Now, the medical liability system is losing information that could be used to improve the practice of medicine. Although the goal of having zero medical errors is lofty, the significant reduction of medical errors should be our true objective in medical liability reform. The Institute of Medicine, in its groundbreaking study, called "To Err is Human," found that preventable medical errors are responsible for the deaths of between 44,000 and 98,000 Americans this year.

In the 7 years since that study, little progress has been made, as the practice of medicine has become more specialized and complex, and the tort system has forced more and more focus on individual blame than on the safety of the system.

Although we would expect our tort system to lead to fewer medical errors, it has not. Perhaps we could live with this flawed system if litigation served to improve quality or safety, but it doesn't. Litigation discourages the exchange of critical information that could be used to improve the quality and safety of patient care.

The randomness and delay associated with medical litigation does not contribute to timely, reasonable compensation for most injured patients. Some injured patients get huge jury awards, while others get nothing at all. It is important to patients and doctors that our justice system is perceived as both efficient and fair.

In addition, the constant threat of litigation also drives the inefficient, costly, and even dangerous practice of overly defensive medicine. Simply stated, overly defensive medicine means the doctor has departed from doing what is best for the patient because of a very real fear of a lawsuit. Defensive medicine can mean ordering more tests or providing more treatment than might otherwise be necessary; for instance, a doctor might order an unnecessary and painful biopsy.

Some estimates suggest that Americans will pay $70 billion for defensive medicine this year. While some have argued this figure is overstated, even if it is half of that amount, it is way too much. Several of our witnesses appearing before the committee today will testify to the facts and figures that show how our system fails to compensate patients quickly and fairly, and as one of our witnesses will point out, injured patients actually receive less than half of the

compensation paid out. Most of it goes to the lawyers, experts on both sides, court costs or elsewhere.

Our medical litigation system is in need of repair. It fails to achieve its two objectives: to provide fair and fast compensation to injured patients and to effectively prevent future mistakes. At its worst, it replaces the trust in the provider-patient relationship with distrust.

Fortunately, the system can be repaired. We can make it better, and with your help and support, we will. We have several witnesses today who are experts on these issues, and I look forward to hearing their testimony and recommendations on how we should improve the system.

Senator Kennedy.

OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. Thank you very much. It is probably useful at this time to mention the leadership that, Mr. Chairman, you have provided the committee in our medical error legislation that we have been able to achieve through the Senate in the recent last year or two. That was very important. A lot of good ideas went into that legislation to help in the reduction of medical errors, and we certainly hope that that will be an asset in terms of the kind of statistics that you mentioned here in terms of the medical errors in our system.

Today's hearing is entitled, "Medical Liability: The New Ideas Making the System Work Better for Patients." Fair treatment for seriously injured patients is certainly the yardstick we should use to evaluate both the current system and proposals that would dramatically change it. Under close scrutiny, it becomes clear that many of the proposed reforms would actually harm seriously injured patients and deprive them of their basic rights.

The historic rights of injured persons, including the victims of medical negligence, to have their claims for compensation decided by a jury is a fundamental part of our democratic process. It is the American way. The medical liability system cannot be made to work better for patients by denying them their basic guarantee of justice.

The right to a jury trial is important to ensure fair treatment in practice as well as in theory. It is the best assurance that an average citizen who has been injured will receive a fair hearing when he or she brings a case against often wealthy and powerful defendants. Numerous empirical studies, including those conducted by two of the witnesses today, Professor David Studdert the Harvard School of Public Health and Professor Neil Vidmar of the Duke Law School, have shown that most juries are conscientious and do render a decision based on the evidence.

Even though only 1 medical malpractice case in 10 actually goes to trial, the fact that defendants know their conduct will be scrutinized by a jury is a major factor in producing fair settlements. In many cases, without the imminence of a jury trial, there would be no reasonable offer of a settlement made by the defendant. The availability of a jury trial benefits injured patients who settle their claims as well as those who try their cases to verdict.

There are several myths that opponents of the jury system rely on that are clearly false and should be rejected at the start of the hearing. First myth is that medical malpractice cases are somehow responsible for the high cost of healthcare. There is no basis in fact for such a claim.

The cost of medical malpractice premiums constitutes less than ⅔ of 1 percent of the Nation's healthcare expenditures each year. Malpractice premiums are not the cause of the high rate of medical inflation. Legislation changing the medical liability system will not make the healthcare more affordable. We have gone up from spending $1.3 trillion a year, which was 5 years ago, up to $1.9 trillion, $600 billion more, on the healthcare system. At the time, we had seen 6 million Americans that had healthcare coverage through the employer-based system who have lost their coverage, so those indicators are going exactly in the wrong way, and we should address them. But this isn't the problem.

The second myth is that restricting an injured patient's right to recover compensation will reduce malpractice premiums. This claim is also false, and comprehensive national studies show that medical malpractice premiums are not significantly lower on average in States that have enacted damage caps and other restrictions on patients' rights than in States without the restrictions. Insurance companies are merely pocketing the dollars which patients no longer receive when tort reform is enacted.

The third myth is that capping how much compensation a seriously injured patient can receive will eliminate frivolous lawsuits. This, too, is false. In reality, such a provision only serves to hurt those patients who have suffered the most severe life-altering injuries and who have proven their cases in court.

One legitimate concern about the current medical liability system is that in some jurisdictions, victims must wait for years for their day in court before a jury. But the answer to the problem of delay is certainly not to deprive the victims of their right to that day in court. To do so would be both unreasonable and unjust. The appropriate response is to provide greater resources to our courts, so that cases, especially those involving disabling injuries, reach trial more quickly.

Mediation programs that are truly voluntary and do not deprive the victims of their right to a jury trial, should efforts to quickly resolve the dispute fail, are also worthwhile. A number of States are already using some form of pretrial mediation and doing it very successfully. However, there is an enormous difference between voluntary mediation programs that can make the system work better for patients and mandatory alternatives such as administrative tribunals and health courts that deprive injured patients of their historic right to a jury trial.

Voluntariness is the first and most fundamental standard by which we should evaluate all alternate dispute resolution proposals. We should reject any proposal that would deny the injured patient the option of taking his malpractice claim before a jury. The patient must be given a genuine choice between a traditional court proceeding and the alternative process.

That choice by the patient must be an informed choice with a full understanding of the rights being relinquished, made after the in-

jury has occurred. That is important. Merely obtaining the patient's signature on one more consent form at the time that he or she visits the physician or enters the hospital is not sufficient. Such pro forma procedures make a mockery of informed consent, turning the principle of voluntary participation into a sham.

Another important standard for evaluating proposed alternatives is whether they permit an individualized determination of the compensation that an injured patient should receive. Imposing a defined compensation schedule will deny the fact-finder the ability to consider the full impact of the injury on the victim's life; will result in an arbitrary ceiling on compensation for those who have suffered the most severe and permanent damages. This would be grossly unfair. Any proposal that will truly make the system work better for patients must meet these standards. Proposed alternatives that fail these basic tenets will only harm the patients they purport to help and should be rejected.

I thank the Chair for having these hearings and look forward to our witnesses.

The CHAIRMAN. Thank you, and I thank you for mentioning the patient safety bill that we worked on together that passed both houses unanimously and will make a difference. I also thank you for your willingness to take a look at other ways that we might expedite or help patients in one way or another. I think we have about 28 healthcare bills that we're working on together. It's quite a load for any committee.

We offered the two groups of people that are working on bills in this area the opportunity to testify. Senator Cornyn has taken us up on that, so it is my pleasure to have Senator Cornyn here to make a statement. He's been drafting his own legislation that will address the issue that we are discussing today, and prior to becoming a U.S. Senator, Senator Cornyn was a lawyer, a district court judge, and then a member of the Texas Supreme Court. I welcome your testimony and look forward to your observations.

Senator Cornyn.

STATEMENT OF SENATOR CORNYN

Senator CORNYN. Thank you, Chairman Enzi and Ranking Member Senator Kennedy. I really appreciate the opportunity to discuss alternatives to our current medical justice system, which I believe has impaired access to healthcare on behalf of many of our citizens. It is enormously inefficient, as Chairman Enzi noted in his opening statement, with tremendous transactional costs, and it is unreliable in terms of its ability to appropriately compensate people who have genuine grievances. So I think we need to look at other alternatives.

I do come to this with some background in the area. Chairman Enzi mentioned my experience as a district court judge and U.S. Supreme Court judge. Before that—I shudder to think; it's 30 years ago when I graduated law school, but when I was in private practice, I represented healthcare providers in medical liability lawsuits, trying to do jury cases. And then, of course, presiding over many of these cases as a judge, trial judge, and then as an appellate judge on the Texas U.S. Supreme Court.

And all of this experience leads me to believe that the current system is irretrievably broken. The incentive structure is perverse. When a mistake occurs, doctors and hospitals are not persuaded or encouraged to come forward, admit the mistake, and work out an amicable solution. Instead, our adversarial civil justice system is corrupting the practice of healthcare in our Nation.

Indeed, the current system fosters widespread errors and decreases patient safety, causes overall healthcare costs to skyrocket, drives up insurance premiums for doctors and hospitals, and worst of all, causes doctors to simply retire early or refuse to go to certain parts of the country that are known as litigation hellholes, and that impairs access on behalf of all of us to healthcare.

Consider the cost of defensive medicine. I think this is really one of the hidden costs that no one really takes into account. The cost of defensive medicine to the Federal taxpayer is estimated to be roughly $28 billion a year. The additional added cost to the health economy is roughly $100 billion a year in unnecessary, preventable defensive medical care costs. And if you think about the usual healthcare provider, let's say an emergency room physician who has never met a patient before but encounters them in a hospital emergency room, certainly, they are going to provide every sort of diagnostic test that could possibly be conceived by the mind of modern medicine, lest they be held to account years later when this same patient, who they perhaps helped, perhaps even saved their life, sues them and challenges them for not exhausting every possibility, even though that doctor's best healthcare judgment and the standard of practice in the area would say that some of those tests were not necessary.

Furthermore, according to the Department of Health and Human Services, a majority of doctors say that they recommended invasive procedures and painful tests they consider unnecessary in hopes of avoiding litigation; in other words, too many of our healthcare providers are not practicing their profession based on what they consider to be sound medical judgments but rather in fear of litigation; and adding to the costs, as I say, of our healthcare services in this country.

As we know, one solution that's been offered is to cap noneconomic liability damages. That's been one of the solutions that my State has adopted with enormous success. We have added nearly 4,000 physicians to our State who have come back into areas where they had formerly refused to go and practice because of these liability reforms, because the cost of medical liability insurance has come down. But, medical liability caps are just one piece in a much larger puzzle and frankly do not address the systemic problems with our healthcare system. And that is, to simply put it, unreliable, unpredictable, random medical justice.

And that is why I have embraced the concept of specialized health courts. I can tell you, as a former judge of a court of general jurisdiction, I have sort of a built-in bias against specialized courts, but as we all know, we do have specialized courts in taxes, bankruptcy, just to name a couple, and I believe the time for healthcare courts or at least a pilot project to test this innovative idea could pave the way to a medical justice system that would promote greater fairness and reliability while also providing reasonable com-

pensation on a reliable basis to patients who are injured due to healthcare treatment.

I know the Chairman of this committee, Chairman Enzi, has joined Senator Baucus to introduce bipartisan legislation that would authorize the Secretary of Health and Human Services to award grants to States for the development of alternatives to resolving disputes over medical errors, alternatives to the current, broken status quo. This bill, your bill, Mr. Chairman, specifically authorizes the creation of special health courts and I welcome and embrace that idea. And really, the legislation that I hope to introduce shortly will build on that idea.

States should be encouraged to find alternative solutions as the laboratories of democracy. The legislation that I am working on would provide for a Federal pilot health court system through the Department of Health and Human Services for voluntary participating hospitals around the Nation. Responsive to the concerns raised by Senator Kennedy, this would provide a system, as I currently contemplate, that would require an administrative process, but if someone is dissatisfied with the administrative process, it would not cut off their right to access the court system and a jury trial under appropriate safeguards.

But these health courts would provide incentives for providers to make early offers in order to promote quality improvement and patient safety through early disclosure of adverse medical events. It would call for the immediate development of pilot alternatives to the current medical tort litigation system and eligible institutions through administrative health courts and provide for a hearing and a written opinion from an administrative judge advised by neutral experts. The judges would make written rulings in every case to provide guidance on proper standards of care.

And I would say in conclusion, that's one of the areas that in my experience both as a lawyer trying medical liability cases and as a judge presiding over these cases is the greatest source of random justice in our system. Everyone knows that for a fee, you can hire an expert to come in and testify to just about anything in a court of law. And it's one thing to have competing witnesses testify who had the red light at an intersectional collision. It is entirely another thing to have experts for hire come in and testify to a standard of care that is not recognized anywhere else in the country, have a swearing match, and then ask a lay jury, without that expertise, to resolve. And it provides no sort of reliable standard that can be used by healthcare providers to determine what, indeed, is demanded of them in our civil justice system.

I hope to introduce this legislation soon. Patients and providers deserve access to care and access to a reliable system of justice. The current system fails on both counts. I support the efforts of this committee to explore alternatives to this broken system and look forward along with you to listening to the testimony. Thanks very much for allowing me to come here today and offer these few words in support of the committee's efforts.

The CHAIRMAN. Well, I thank you for being here and sharing that with us, and if you have a longer statement you'd like to submit for the record, please do so. I'll be making this offer to the witnesses today, and also, to Senator Clinton and Senator Obama, so

that we can get their ideas and put them in the record unless there is disagreement.

Senator CORNYN. Mr. Chairman, if I could just interject one thing, I would be remiss if I did not acknowledge the great contribution that Common Good has made in this effort, as you know, to introduce this concept of specialized health courts, and as you know, there is an ad in the New York Times today, a half-page ad: it's time to create special health courts, noting that Duke University School of Medicine, Emory Health Care, Johns Hopkins Medicine, and the Yale Hospital Health Care System have indicated their interest in participating in a voluntary pilot project should Congress create a system whereby they could do so.

Thank you very much.

The CHAIRMAN. Thank you.

Senator KENNEDY. Chairman, could I just introduce a paper also by the Alliance for Justice, Center for Justice and Democracy, USAction, Public Citizen that is on this subject?

The CHAIRMAN. Sure.

[The information follows:]

ALLIANCE FOR JUSTICE, CENTER FOR JUSTICE AND DEMOCRACY,
PUBLIC CITIZEN, USACTION,
June 20, 2006.

Hon. MICHAEL B. ENZI, *Chairman,*
Committee on Health, Education, Labor, and Pensions
U.S. Senate,
Washington, DC. 20510

Hon. EDWARD M. KENNEDY, *Ranking Member,*
Committee on Health, Education, Labor, and Pensions,
U.S. Senate,
Washington, DC. 20510

DEAR CHAIRMAN ENZI AND SENATOR KENNEDY: We understand the Health, Education, Labor, and Pensions Committee will be holding a hearing this week on several bills to promote patient safety and reduce litigation stemming from medical error and injury.

We are supportive of the concept envisioned in S. 1784 of a national patient safety database that would permit the comprehensive collection and analysis of data about medical error. The disclosure and compensation program also proposed in S. 1784, which draws on the experience of existing voluntary programs including the Rush Mediation Program in Chicago, appears to be a common sense reform in cases of medical error where liability is clear. These programs have been successful because the parties participate voluntarily using a mediator to resolve compensation issues. They do not take away the claimant's right to litigation if the parties fail to come to agreement.

The State demonstration programs proposed in S. 1337, on the other hand, would eliminate medical litigation entirely. In order to apply for the demonstration funding, States must "develop an alternative to current tort litigation for resolving disputes over injuries allegedly caused by healthcare providers or healthcare organizations." Injured patients would be subject to a mandatory alternative system for resolving compensation claims, and their right to a jury trial would be eliminated. Experience with other alternative compensation systems, on which these programs are based, strongly suggests that they will provide worse protection for patients than the civil justice system currently provides.

While S. 1337 gives States a choice of three different demonstration models, they all share the same characteristics. The jury trial is replaced by a vaguely defined administrative bureaucracy run by political appointees charged with developing uniform schedules of compensation for specific medical injuries. These schedules in reality act as the kind of damage cap that a number of State courts have found unconstitutional. The development of a rigid payout schedule for compensation is particularly problematic because it remains unclear whether the schedule can be determined in a fair manner.

All three of these models may be unconstitutional under both Federal and State law because they preempt all constitutional guarantees to trial by jury without providing the constitutionally necessary *quid pro quo* of eliminating the injured parties' burden of proving fault. While the models appear to mimic the workers' compensation no-fault administrative concept, injured parties would retain the burden of proving fault.

Finally, we are deeply concerned about replacing State civil justice systems, some of which have functioned for centuries, with what are frankly unknown quantities lacking any kind of established operating procedures. One key question is how patients will get access to information regarding their claims and injuries. In civil litigation, parties are entitled to discovery of facts from the other side. With respect to the models in S. 1337, it is unclear whether patients would be entitled to review medical records and interview potential witnesses. It is also unclear how much information patients will be entitled to obtain before filing a claim, how much information patients will be provided after a claim is filed, what kind of evidence will be allowed, whether expert witnesses may be called, and what standards would be used to determine admissibility.

Given the dearth of information about how these models would work, it is difficult to understand how S. 1337 achieves its purpose "to restore fairness and reliability to the medical justice system." The civil justice system is not perfect, but like democracy, it's better than the unknown alternative. Problems with the way medical injuries are processed through the civil justice system can be resolved, and the system improved, by common sense reforms, some of which are conceptualized in S. 1784.

Thank you for taking time to understand our concerns. We look forward to working with you on legislation to improve patient safety in the healthcare system. Please do not hesitate to contact Dick Woodruff at Alliance for Justice, 202–822–6070 if we may be of further assistance.

Sincerely,

NAN ARON,
President, Alliance for Justice.

JUNE 21, 2006.

Hon. MICHAEL B. ENZI, *Chairman,*
Committee on Health, Education, Labor, and Pensions,
U.S. Senate,
Washington, DC. 20510.

Hon. EDWARD M. KENNEDY, *Ranking Member,*
Committee on Health, Education, Labor, and Pensions,
U.S. Senate,
Washington, DC. 20510.

DEAR SENATORS ENZI AND KENNEDY: As survivors of medical negligence who once used the legal system to obtain compensation and justice, we are strongly opposed to the establishment of "Health Courts" to resolve malpractice claims. While ostensibly being for the benefit of victims like us, the outline of this proposal shows misguided concern for what is best for patients and, particularly, the most severely injured patients.

First, please note that we have no problem with pre-trial settlements, in which both parties voluntarily agree to take malpractice cases out of the civil justice system. In fact, many of us took advantage of a voluntary settlement process to resolve our cases.

However, schemes like Health Courts, which *require* that cases be heard in an informal setting, without the option of having either juries or unbiased judges make decisions, and with compensation judgments determined by political bodies who can be lobbied by insurance and health industry representatives, would be highly unjust. Though promising to be a quick, fair and cost-effective method of obtaining resolution, Health Courts will actually obstruct the most seriously injured patients' path to justice, making it more likely that he or she will drop a legitimate claim altogether. This is especially true because the burden of proof on patients who are forced into the Health Court process is little different than would be required in a court of law. And, our experience with similar alternative systems, like mandatory arbitration, shows that insurance defense lawyers can be abusive toward patients when there is no unbiased judge to ensure fairness.

Moreover, removing the possibility of litigation would disrupt other critical functions of the legal system, most importantly the deterrence of unsafe practices, especially in hospitals. On May 11, 2006, the New England Journal of Medicine pub-

lished an article showing how litigation against hospitals improves the quality of care for patients. The article also confirmed that removing the threat of litigation, as this proposal contemplates, would do nothing to improve the reporting of errors since fear of litigation is not the main reason doctors do not report errors.

Instead of taking compensation decisions away from juries and putting them in the hands of those who may be biased against patients, we should look for ways to improve the quality of healthcare services in our country and to reduce preventable medical errors. It is well established that State disciplinary boards do little to weed out the small number of doctors responsible for most malpractice. 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 healthcare providers.

Health Courts will not only fail to fully compensate patients, but they will also undermine restraints the civil justice system now imposes on dangerous conduct. Mechanisms that shield grossly negligent doctors from accountability by intruding upon the legal system and eliminating individual's right to sue should not be tolerated by a society that believes in our constitution and democracy.

Sincerely,

JOANNE DOROSHOW,
Executive Director, Center for Justice & Democracy.

(For: Paula Andrasko, Akron, OH; Sheila Austin, St. Elmo, IL; Barbara Becker, Evansville, IN; Michael Bennett, Baltimore, MD; Alan & Christian Buckley, New York, NY; Bob Carmody, Chicago, IL; Diane Carter, Galena, IL; Deborah K. Dick, Kenton, OH; Mark & Michelle Geyer, Antioch, CA; Elie & Kathy Ghawi, St. Charles, IL; Deborah Gillham, Gaithersburg, MA; Lisa & Michael Gourley, Valley, NE; Melinda Hause, Palm Coast, FL; Marlene Jacobson, Omaha, NE; Garret & Julie Koleszar, Fallbrook, CA; Leslie Lewis, New York, NY; Justin Mattes, Woodcliff Lake, NJ; John J. McCormack, Pembroke, MA; Dianne K. Meyer, Las Vegas, NV; Patricia Nelson, North Yarmouth, ME; Susan P. O'Bernier, Naugatuck, CT; Patti O'Regan, Port Richey, FL; Tammy Schilt, West Salem, IL; David & Patricia J. Skolnik, Centennial, CO; David Snow, Colchester, CT; Kelly Spetalnick, Atlanta, GA; Sue & Jay Stratman, Chesterfield, MO; Mary Steinberg, Chicago, IL; Debi Surlas, Aurora, IL; Stephen K. & Karen E. Swain, Gahanna, OH; Pamela Thomas, Illiopolis, IL; Lisa Waligorski, Albers, IL.)

Senator KENNEDY. Could I ask one question?

On these courts that you mentioned, mediation, do you have them in Texas? Are you personally familiar with them? I know that they do exist in a lot of the States. I was just wondering whether you had any familiarity with any of the ones.

Senator CORNYN. Senator Kennedy, I am very familiar with the introduction of what has generally been known as alternative dispute resolution, which is designed to address the problems that we have identified here in a general context; that is, the cost of people resolving their disputes in the current court system, because we know that cost frequently freezes some people out and the delays associated with our civil justice system.

We don't have health courts or anything quite like that in Texas now, but this is another effort to build on, I think, the alternative dispute resolution approach to try to provide more efficient, more timely, less expensive justice.

Senator KENNEDY. Good, good. Thank you.

Senator CORNYN. Thank you.

The CHAIRMAN. Thank you very much for your testimony today and for taking the time to be here. Thanks.

And we will now call to the table our panel of witnesses. I will go ahead and introduce the panel as they're taking their places. Again, I appreciate the time you've all taken to come today to testify and answer some questions. And we do have a vote that—actually, several votes that start at about 11:00, so any help that you can give us by condensing your testimony will be very much appre-

ciated. Your full statement and any other comments you want to expand on will be a part of the record, and of course, we will ask that you answer any questions that we submit to you in writing as well. Sometimes, those are as beneficial as ones that we would get to ask in the open hearing.

So on this panel of witnesses, from my left to right, we have Professor David Studdert. Professor Studdert is an associate professor of law and public health in the Department of Health Policy and Management at Harvard University School of Public Health. Professor Studdert will tell us about his most recent study on the outcomes of medical malpractice.

Then, we have Philip Howard. Mr. Howard is a partner at the law firm of Covington and Burling and is the chair and founder of the organization Common Good. Mr. Howard is the author of the book The Death of Common Sense. Mr. Howard will discuss the health court model that Common Good has developed.

Then, we have Professor William Sage, who is a professor of law at Columbia Law School. Professor Sage provides us with a unique perspective on this discussion, as he is both a doctor and a lawyer. Professor Sage will discuss alternatives to medical litigation.

Next to Mr. Howard, we have Richard Boothman, who is chief risk officer at the University of Michigan Health System. Mr. Boothman has brought his son with him, whom I would also like to welcome to the hearing.

Senator KENNEDY. Can you stand up?

The CHAIRMAN. Yes, would you stand up?

[Laughter.]

Thank you, and thanks for being here.

Mr. Boothman will discuss the model that's been developed at the University of Michigan and its applicability to other places.

Then, we have Susan Sheridan, who is the cofounder, President of Consumers Advancing Patient Safety, CAPS. Her organization advocates for making changes to the medical malpractice system in order to improve patient safety. Ms. Sheridan will provide a personal account of our medical litigation system and will share her views on how it might be changed to better serve patients. I respect and thank her for her willingness to speak today on an issue that has affected her family so directly.

And then, next to her, we have Cheryl Niro, who is an attorney for the law firm of Quinlan and Carroll. Ms. Niro is the former president of the Illinois Bar Association. Today, she's speaking on behalf of the American Bar Association, which is the largest association of lawyers in America. At the ABA, she is on the Standing Committee on Medical Professional Liability. She will describe the ABA's concern about health courts.

And finally, we have Professor Neil Vidmar, who is the Russell M. Robinson II professor of law at the Duke University School of Law. He is also the author of the book Medical Malpractice and the American Jury. Professor Vidmar will share his thoughts on the issue, specifically on the role of juries in medical litigation.

At this time, I will ask for unanimous consent that the testimony of the American College of Obstetricians and Gynecologists be entered in the record. I thank each of you for taking the time to join

us today, and again encourage you to condense as much as possible so that we will have time for some questions.

Mr. Studdert.

STATEMENTS OF DAVID STUDDERT, ASSOCIATE PROFESSOR OF LAW AND PUBLIC HEALTH DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HARVARD UNIVERSITY SCHOOL OF PUBLIC HEALTH; PHILIP HOWARD, FOUNDER AND CHAIR, COMMON GOOD; WILLIAM M. SAGE, PROFESSOR OF LAW, COLUMBIA LAW SCHOOL; RICHARD BOOTHMAN, CHIEF RISK OFFICER, UNIVERSITY OF MICHIGAN HEALTH SYSTEM; SUSAN E. SHERIDAN, CO-FOUNDER, PRESIDENT, CONSUMERS ADVANCING PATIENT SAFETY (CAPS); CHERYL NIRO, AMERICAN BAR ASSOCIATION, STANDING COMMITTEE ON MEDICAL PROFESSIONAL LIABILITY; AND NEIL VIDMAR, RUSSELL M. ROBINSON II PROFESSOR OF LAW, DUKE UNIVERSITY SCHOOL OF LAW

Mr. STUDDERT. Thank you, Mr. Chairman, for the privilege of testifying, Senator Kennedy, on options for improving the medical liability system in the United States. I'm honored to be here, and I commend the committee for taking up this very important issue.

I am an associate professor of law and public health at the Harvard University School of Public Health. The chairman gave a little bit about my background, so I won't say much more about it. I've been conducting research on the malpractice system and on medical injury for about 10 years. In the mid-1990s, I was part of a research group at the Harvard School of Public Health that did work in Utah and Colorado to try to estimate the incidence of medical injury there. That work, together with our earlier work in New York formed the basis of the Institute of Medicine's 2000 report on medical error, "To Err is Human."

I believe that patients stand to benefit from improvements to the way the legal system compensates and prevents injury. I also believe that real improvements in this area depend on moving the policy discussion, as this committee is doing, beyond the debate over the pros and cons of traditional tort reforms like caps on damages, screening panels, attorney fee limits.

What these traditional reforms will achieve is controversial and hotly disputed, including in this place. However, two things that they will not achieve are relatively clear and I would submit beyond serious debate. They will not make healthcare safer, and they will not grapple seriously with several fundamental problems that the system has. Those are different goals, and they call for more creative solutions.

Last month, the New England Journal of Medicine published results of a study by my research group on the performance of the malpractice system. Our study involved review of about 1,500 medical records and claims files from five liability insurers. We tackled two main questions: How often did malpractice claims lack merit, and How often did claims which lacked merit receive compensation?

What did we find? We found that nearly every claim involved some kind of injury from medical care, but about a third of these injuries could not be linked to errors in the care. In resolving the

claims, the system got it right about three-quarters of the time; that is, about three out of four claims that lacked merit were denied compensation, while three in four meritorious claims got paid.

Now, one conclusion from the study is that the malpractice system appears to be doing a reasonable job in the task of directing compensation to the right claims. To infer that study's message is that the liability system is working well, however, as a number of commentators have done, is simply not correct. Compensating litigated claims correctly is one item in the overall systems scorecard. There are other important items, and looking at the whole picture shows up some troubling issues. I want to very briefly touch on four of those issues that have emerged from our recent work, our previous work, and also from the work of other researchers across the country over the last 20, 25 years.

Problem No. 1, the process is just simply too costly. Resolving malpractice claims is an expensive business. Our recent study suggests that for every dollar paid in compensation to plaintiffs, 54 cents goes toward administrative costs; that is, the costs of lawyers, experts, insurers, and so forth, and there are other studies to support a figure in that range.

Compared to other compensation systems, this is a tremendously high overhead rate. The equivalent figure for workers compensation schemes, for example, is generally in the 20 to 30 percent range. For many disability insurance schemes, it runs as low as 10 to 15 percent. The National Vaccine Compensation Program spends around 15 percent of its budget on administrative expenses and attorneys' fees. The system is also slow, taking 4 to 5 years on average to resolve claims.

Problem No. 2, many patients who sustain injury due to negligent care don't get compensated. In fact, this is true for the vast majority of them. Only a tiny fraction of negligently injured patients, about 3 to 5 percent, based on our research in New York in the eighties and in Colorado in the nineties, will have any contact with the legal system at all. The rest either don't know they've suffered an injury or are unable to navigate their way through the system. Consequently, they must shoulder the financial burden themselves.

Now, in debating the merits of tort litigation and juries, I would urge the committee not to lose sight of this invisible population, literally thousands of people who suffer preventable injuries every year and don't get help. The current system doesn't serve them well. To be effective, reformers will need to link more of them with compensation.

And I might digress for a moment and say what about juries. I don't consider juries to be one of the chief vices of the current system, and the reason is because of a couple of very important statistics: we think that there are about 60,000 malpractice claims closed in the country every year. Now, about 3,000 to 4,000 of those will go before a jury, so for the rest, 55,000, 56,000 claims a year are resolved out of court.

Now, it is very important that the system work well for that large body of claims, and I would urge discussion around this issue not to hold the interests of the many hostage to the interests of a few when there are questions, in fact, about how well juries, pa-

tients, and plaintiffs sometimes—Professor Vidmar will talk about the ways in which juries are not biased in favor of plaintiffs, and I would readily agree with much of what he has to say. I worry about the opposite, that they, in fact, are biased against plaintiffs, and this is the other statistic which I would urge the committee to consider: plaintiffs lose four in five jury verdicts. They don't do well in front of juries, and we need a system that will ensure that they do well, however their claim is resolved.

Problem No. 3 is defensive medicine. That's been discussed, so I won't go into it in any depth. We don't really know how prevalent defensive medicine is. There are not good statistics on that. We don't really know what its health impact is, and we don't know how much it costs, but there is solid evidence that it exists, and a number of studies have suggested that its adverse impact may be quite substantial.

Problem No. 4, our liability system is not terribly compatible with quality improvement and transparency about error. This friction here between the malpractice litigation system and healthcare system efforts to improve quality and safety; trial attorneys believe that the threat of litigation is needed to make doctors accountable and make doctors think seriously about safety. Physicians and most patient safety experts think it has the opposite effect.

Randall Bovbjerg has called this a problem of two cultures. Which culture is right? This is the subtext, I would suggest, in the ongoing debates between organized medicine and much of the trial bar. In the absence of evidence from alternative approaches to compensating medical injury, this is surely an unending and unwinnable debate. Do injured patients do better in healthcare environments where adversarial tort litigation governs access to compensation? Or do they do better under alternative arrangements? We simply do not know the answer to that question, but we could find out. Innovative demonstration projects would help us find out.

So I would suggest there is a need for reforms that address these four problems. I believe that real and lasting improvement in the system depends on it. The reforms should have the following central goals: make compensation more accessible to patients who are injured by preventable medical errors; make the process faster and cheaper; ensure more accurate and reliable decisions, more accurate and reliable than we already have; and strive to make the system less threatening to doctors if possible and compatible with transparency about errors.

I believe that demonstration projects at the State level to evaluate alternatives to medical tort litigation are a very good place to start. How successful they are and how well they deliver on the goals I mentioned will depend on the details of their design.

With support from the Robert Wood Johnson Foundation and in collaboration with Common Good, our research group at Harvard has been working on the design of an alternative structure, one that has the potential to deliver on the goals I enumerated and to address these key shortcomings that I've mentioned. There's a draft of that. It is a work in progress, but there is a draft of that, and we hope it might be useful to States that take up this type of experiment if, in fact, legislation is passed that allows them to do that.

In summary, the key design features of the model we outline are a focus on preventability rather than negligence; a nonadversarial structure with an administrative law judge in charge of compensation decisions to be made on the basis of advice from a neutral panel of medical and scientific experts; and ties to other agencies and actors engaged in patient safety improvement activities.

For the model to work properly, I believe that it must operate as an exclusive avenue for compensation among patients and doctors who are covered by the program. Allowing opt-ins or opt-outs after an injury has occurred would undercut the program's ability to make a difference.

So in conclusion, besides health courts, there are a variety of other innovative alternative dispute resolution mechanisms. Some have been mentioned. There's the early offer program, which has the potential to avoid the passion play of litigation, and in general, I think that these ADR approaches are good. I think they're less ambitious than health courts, and in my opinion, they do not carry quite the same potential for broad system improvement. Nonetheless, I think reducing the time and cost would be a valuable step forward.

There are many unknowns about how well these alternatives such as health courts and early offers will work, but they have tremendous promise. Therefore, I think the appropriate next steps are launching demonstration programs and carefully evaluating how well these models have performed relative to tort litigation.

[The prepared statement of Mr. Studdert follows:]

PREPARED STATEMENT OF DAVID STUDDERT, LLB, ScD, MPH

SUMMARY

I believe strongly that patients in the United States would benefit from improvements to the way the legal system compensates and prevents medical injury. I also believe that real improvements in this area depend on moving the policy discussion beyond debate over caps on damages.

One of the perplexing aspects of the tort reform debates of recent years is that they rarely engage over the system's true failings. Instead, they tend to fixate on the pros and cons of damages caps and other traditional tort reforms, and ponder what these reforms might accomplish. Even if these reforms are highly successful in accomplishing their objectives—namely, reducing the number of claims, the size of payments, and growth over time in the premiums physicians pay for liability insurance—they will not make healthcare safer, nor will they grapple seriously with the medical liability system's fundamental problems. Those are different goals that call for more creative solutions.

What are the medical liability system's fundamental problems? There are good reasons to criticize the system's performance, but it is important to do so for the right reasons. The diagnosis matters because it informs the treatment. A considerable body of empirical research into the workings of the medical malpractice system has highlighted the following three problems as especially troubling:

1. Many patients who sustain injury that is both severe and preventable do not receive compensation.
2. The process of deciding whether a claim is compensable is too slow and expensive.
3. The threat of litigation provokes defensive medicine, but does not stimulate improvements in the quality of healthcare services.

An alternative to medical malpractice litigation that focused on preventable injuries (rather than negligence and provider fault) and was nonadversarial (with an administrative body making compensation decisions with advice from neutral experts) has tremendous potential to address these ills. It could achieve significant advances in making:

- Compensation more accessible to patients who sustain preventable injuries;

• The process of determining eligibility for compensation faster and cheaper;
• Compensation decisions more accurate and reliable (ideally through incorporation of the best available clinical evidence into decisionmaking);
• Assessments of damages more accurate and reliable; and
• The system less threatening to doctors, while encouraging transparency about errors.

Much is unknown about how well such an alternative would work. Therefore, the appropriate next steps are the launching of demonstration programs followed by careful evaluation to assess how well the alternative models perform relative to tort litigation. If States are given latitude and incentives to do this, and the alternative models are carefully and thoughtfully designed with the interests of injured patients as their guiding principle, there is tremendous potential to address the current system's fundamental shortcomings and provide patients in the United States with a better system for compensating medical injuries.

Thank you for the opportunity to testify before you today on new strategies for improving the medical liability system in the United States. I am honored to be here, and I commend the committee for taking up this important issue.

I am Associate Professor of Law and Public Health at the Harvard School of Public Health. I am a lawyer and health services researcher. I have been conducting research on medical injury and the malpractice system for more than 10 years. In the mid-1990s, I was part of a research group at the Harvard School of Public Health that investigated the incidence of medical injury in Utah and Colorado. Findings from this work, together with the group's early work in New York, formed the basis of the Institute of Medicine's 2000 report on medical error, *To Err is Human*.

I believe strongly that patients in the United States would benefit from improvements to the way the legal system compensates and prevents medical injuries. I also believe that real improvements in this area depend on moving the policy discussion beyond debate over the pros and cons of caps on damages. Although there has been a good deal of consideration of malpractice reform in Congress and State legislatures over the last few years, damages caps and other conventional tort reforms (e.g., screening panels, attorney fee limits) have tended to dominate the discussion.

How well these conventional reforms work is controversial. The empirical research evaluating their efficacy has produced conflicting results.[1] A generous interpretation of the results might concede that a few (but not most) of these reforms return modest gains on their objectives—namely, reducing the number of claims, the size of payments, and growth over time in the premiums physicians pay for liability insurance. What is clear about conventional tort reforms such as damages caps, however, is that they will not make healthcare safer, nor will they grapple seriously with the medical liability system's key problems. Those are different goals that call for more creative solutions.

In the first part of my testimony, I will outline a series of problems with the performance of the medical liability system—problems that, in my view, have been established as important and enduring beyond any reasonable doubt by empirical research over the last 30 years. I will begin by reviewing findings from a recent study by my research group at the Harvard School of Public Health. In the second part of my testimony, I will discuss some promising reforms, including ones currently before Congress, and their potential impact.

FINDINGS FROM RECENT HARVARD STUDY OF THE MALPRACTICE SYSTEM

Last month the *New England Journal of Medicine* published the results of a study I conducted, with collaborators from the Harvard School of Public Health and the Brigham and Women's Hospital, on the performance of the medical malpractice system.[2] The findings generated considerable media interest, especially in the press. What did we find? That may depend on which story you happened to read.

Some outlets ran headlines like, "Most malpractice claims are legitimate, study says." Others announced, "Study asserts many medical malpractice suits groundless." The American Medical Association's response began, "Today's study is proof positive that meritless medical liability lawsuits are clogging the courts . . ." The Association of Trial Lawyers for America (ATLA) declared, "New study shows courts not clogged with frivolous medical malpractice lawsuits."

These reactions are not surprising. The warring parties—typically the medical profession and their liability insurers versus the plaintiffs' bar and various consumer advocacy groups—are prone to extreme claims about the system's vices and virtues. Often, these claims are little more than partisan rhetoric, unsupported by

hard evidence about how the system actually performs. Even when that evidence is at hand, each side tends to spin it to their own advantage.

What *did* we find? Our study involved review of nearly 1500 malpractice claim files from 5 liability insurers. Claim files consist of documents gathered by defense insurers during the life of the claim. They include descriptions of the allegation and outline what happened. They usually include the testimony of experts from both sides. Each plaintiff's medical record was also examined. The reviews were conducted by specialist doctors whose training matched the clinical issues in the claims.

The study addressed two questions: How often did malpractice claims lack merit? And how often did claims which lacked merit receive compensation? Claims were classified as lacking merit if the reviewer determined that, in his or her clinical opinion, the plaintiff had not sustained an injury attributable to medical error.

We found that nearly every claim involved some kind of injury from medical care, but that about a third of these injuries could not be linked to errors in care. In resolving claims, the system "got it right" about three quarters of the time—that is, three in four claims that lacked merit were denied payment while three in four meritorious claims got paid.

Do these results represent a passing grade for the system or a failing one? The answer depends partly on one's expectations going in. Those who believe the system should attract only legitimate claims and reject every single illegitimate one will see red flags. But these are unrealistic expectations. Sometimes patients and their attorneys don't understand what has happened. They know a serious and unexpected adverse outcome has occurred, but not why, and litigation may be the only way they can find out. Also, the reviewers felt that some error judgments were "close calls." It seems wrong to label such claims as frivolous.

The bottom line from the study is that the malpractice system appears to be doing a reasonable job in two specific aspects of its performance: (1) it is not consistently or predominantly attracting claims that are patently spurious; and (2) it is usually directing compensation to meritorious claims and denying compensation to nonmeritorious ones. These findings are supported by a number of other previous studies which suggests that the malpractice system does okay in "sorting the wheat from the chaff."

To interpret this pair of findings as indicating that the medical liability system "works," however, would be wrong. Compensating litigated claims accurately is just one item in the system's overall performance scorecard. There are other important items, and an examination of evidence regarding the system's performance in these areas paints a more sobering picture.

Three additional findings from our recent study point to shortcomings that are both serious and well-documented in malpractice research.

1. The process is too costly.

Resolving malpractice claims is an expensive business. Our findings suggested that for every dollar paid in compensation to plaintiffs, 54 cents go toward administrative costs—that is, the costs of lawyers, experts, insurers, and so forth. (A RAND investigation of the tort system the mid-1980s found similar levels of administrative costs.[3])

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 percent range.[4] For many disability insurance schemes—public and private—it runs as low as 10–15 percent.

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 a dime in the current system because their claims never come forward. Thousands of patients each year face this plight; it is a major problem to which I will return shortly.

Another telling feature of administrative costs in medical malpractice litigation is where they get spent. Among the claims we investigated in our recent study, 80 percent of the administrative costs were absorbed in the resolution of claims that involved harmful errors. In other words, most of the high overhead costs go toward resolving legitimate claims, not unjustified aberrant claims. This finding highlights the fact that the process of working through the question of medical negligence in an adversarial framework is lengthy and costly. It also suggests that reform efforts that focus on whittling down the amount of frivolous claims will have limited potential to reduce direct system costs. (Tallying the compensation and administrative costs of claims without error, we estimated that eliminating all of them would save no more than 13–16 percent of the system's total direct costs.) Instead, major sav-

ings depend on reforms that reconfigure the entire process in ways that improve efficiency in handling reasonable claims for compensation.

2. Unpaid errors outnumber paid nonerrors.

Although the number of nonmeritorious claims that attracted compensation in our study was fairly small, the converse form of inaccuracy—claims with error and injury that did not receive compensation—was substantially more common. One in six claims was an unpaid error. Plaintiffs in such situations must shoulder the hardships that flow from preventable injury.[5] Moreover, unpaid errors among litigated claims add to a larger phenomenon of underpayment generated by the vast number of negligent injuries that never surface as claims (see below).

3. Plaintiffs tend to do poorly in medical malpractice jury trials.

In a forthcoming paper, we have analyzed risk factors for the discordant outcomes—that is, claims without errors that were paid and claims with errors that were not paid—identified in our study.[6] We were particularly interested in whether claims involving unpaid errors exhibited any distinctive characteristics.

We were somewhat surprised to find that one of the strongest predictors of unpaid errors was resolution by jury verdict. The odds that a claim involving error would be denied compensation were about 4 times higher in cases decided by juries. This finding held even after controlling for some of the other factors that may have made claims that went to trial different from their out-of-court counterparts. (For example, litigation theory suggests that cases that proceed to trial will involve closer calls about whether negligence occurred, so we controlled for case complexity in our analyses).

What does this finding mean in the real world? It means that, contrary to the popular wisdom, juries tend to be tough on plaintiffs. Jury trials are an important part of our civil justice system in many respects: they help set acceptable standards of care; they are free from the influences of governments, businesses, and special interests (in theory, at least); and they are truly democratic institutions. However, none of these virtues should be confused with the evidence that plaintiffs in malpractice litigation do not do well in front of juries. Malpractice claims data indicate that 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 plaintiff's lawyer in moving the litigation to this point are borne by the successful plaintiff, removed from their award through contingent fees.

Finally, and perhaps most important to keep in mind evaluating different reform options, the vast majority of medical malpractice claims will not go before a jury. National statistics suggest that only about 5–10 percent 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 designing and choosing among reforms, 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.

PROBLEMS IDENTIFIED IN OTHER RESEARCH

The insights into the malpractice system that flow from our recent study join those from other empirical research that has assessed how well the system performs in its various functions. By and large, the picture is not a positive one. Three shortcomings stand out.

1. Many patients who sustain preventable injury don't get compensation.

Although the spotlight usually shines on the malpractice system's excesses, the reality is that the vast majority of patients who sustain injury due to negligence never sue and never receive compensation. Only a tiny fraction of patients injured seriously by medical care—about 3–5 percent based on our research in New York in the 1980s and Utah and Colorado in the 1990s—will have any contact with the legal system.[7] The rest either do not know they have suffered injury, or are unable to navigate through the system to get their claim filed and paid. Consequently, these patients must shoulder considerable financial and personal burdens.

Policy debates and research (including our own) tend to focus on how well the system does in compensating patients who step forward with legitimate claims. However, we should not forget the thousands of injured patients who are invisible. The current system does not serve them well. To be effective, reforms will need to link more of these patients with compensation.

2. Defensive medicine is a problem.

Defensive medicine refers to changes in the way care is delivered—the ordering of unnecessary tests, for example, or ceasing to perform high-risk procedures—which are motivated by fear of litigation, rather than good medical practice. 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 healthcare system. But there is solid evidence that it exists, and its adverse impact may be very substantial.[8] Our recent research in Pennsylvania 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.

3. Our liability system is incompatible with quality improvement and transparency about error.

There is friction between malpractice litigation and the quest to improve the quality and safety of medical care.[9] Trial attorneys believe that the threat of litigation is needed to make doctors accountable, and that it ultimately makes doctors practice more safely (even though most empirical research has not found evidence of such a deterrent effect.[10]) Physicians do not believe the litigation contributes to the quality of care.[11] On the contrary, they argue that the malpractice system threatens quality, both by chilling interest in openness and quality improvement activities and by stimulating the kind of defensive medical practices described above. Hospital executives appear to share this view, an outlook exemplified by the fact that many hospitals continue to conceive of risk management and quality improvement as substantively different enterprises.

Randall Bovbjerg has aptly called this a problem of two cultures.[12] Tort law's punitive, individualistic, adversarial approach is antithetical to the nonpunitive, systems-oriented, cooperative strategies espoused by patient safety leaders. Litigation entails secrecy and blame, whereas modern quality improvement strategies demand transparency and focus on systems of care, not individuals.

Which culture is right? This is the subtext in ongoing battles between organized medicine and the trial bar. In the absence of evidence from alternative approaches to compensating medical injury, this is surely an unending and unwinnable debate. Do injured patients do better in healthcare environments, where adversarial tort litigation governs access to compensation, or do they do better under alternative arrangements? We simply don't know, but we could learn. The time to test reforms that help us to find out is past due.

NEW REFORM OPTIONS

In summary, the medical liability system is plagued by five fundamental problems: (1) the process is too slow and costly; (2) many patients with severe injuries miss out on compensation, sometimes because their legitimate claims are not paid but much more often because they are unaware of their injury or are unable to bring a claim; (3) juries do not decide the vast majority of claims, and when they do, plaintiffs usually lose; (4) defensive medicine drives up costs and reduces quality; and (5) the current system is in tension with goals of quality improvement and transparency about error.

This set of problems strikes the malpractice system at its core. They cannot be addressed by tweaks. Damage caps are a tweak. The same is true of screening panels, which aim to weed out illegitimate claims at an early stage. (Incidentally, studies consistently find that these panels don't save much.)

What is needed are reforms that grapple seriously with the system's fundamental problems. The goals should be to make:

- Compensation more accessible to patients who sustain preventable injuries;
- The process of determining eligibility for compensation faster and cheaper;
- Compensation decisions more accurate and reliable (ideally through incorporation of the best available clinical evidence into decisionmaking);
- Assessments of damages more accurate and reliable; and
- The system less threatening to doctors and encourage transparency about errors.

I believe that State demonstration programs to evaluate 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, our research group at the Harvard School of Public Health, in collaboration with Common Good, has been working on the design of an alterative structure that has the potential to deliver on the goals enumerated above and address the current system's key shortcomings. We have sketched out the structure of what we believe is a promising "health court"

model. The design was informed by extensive consultation with stakeholder groups. It is described in the attached document (**Appendix A**).

In summary, the key design features of the model we have outlined are: (1) a focus on preventability, as opposed to negligence or fault, as the central criterion for determining eligibility for compensation; (2) a nonadversarial structure, with an administrative decisionmaking body in charge of compensation decisions to be made on the basis of advice from a neutral panel of medical and scientific experts; and (3) ties to other agencies and actors engaged in patient safety improvement activities.

If legislation were passed allowing demonstration projects to go forward, we hope this model will be useful to States that become interested in testing an alternative approach.

Besides health courts, there are a variety of innovative alternative dispute resolution (ADR) approaches that warrant serious consideration. ADR approaches have the potential to avoid the passion play and cost of full-blown litigation, and in so doing they promise returns on a number of the goals set forth above. The ADR approach that has enjoyed the widest appeal in recent years is the "Early Offer" program, in which patients and the healthcare organization would have incentives to negotiate private settlements immediately after an event occurs.[13] Such a program is less ambitious than health courts and, in my opinion, does not carry the same potential for broad system improvement. Nonetheless, contracting the time and cost of litigation in this way would be a valuable step forward.

Much is unknown about how well alternatives to traditional malpractice litigation will work. Therefore, the appropriate next steps are the launching of demonstration programs followed 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 over the system's true failings. Instead, they tend to fixate on the damages caps and other traditional, oft-tried reforms. From a long-term, system-wide perspective, the problems these reforms seek to solve are quite narrow.

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, reforms must tackle the core problems. The considerable body of research into the workings of the medical malpractice system's over the last 30 years has highlighted the following three problems as particularly serious:

1. Many patients who sustain injury that is both severe and preventable do not receive compensation.
2. The process of deciding whether a claim is compensable is too slow and expensive.
3. The threat of litigation provokes defensive medicine, but does not stimulate improvements in the quality of healthcare services.

Alternative approaches to compensating medical injury, such as the health court model, have the potential to improve performance in each of these areas and provide patients in the United States with a better system for compensating medical injuries.

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APPENDIX A

DESIGN OF A "HEALTH COURTS" SYSTEM DEMONSTRATION—EXECUTIVE SUMMARY

(DRAFT)

BACKGROUND

The Harvard School of Public Health and the advocacy organization Common Good have been working to develop a proposal for the design and operation of "health courts"—special courts for resolving medical injury cases and compensating injured patients. This document summarizes the current proposal. **The proposal is a work in progress, and will continue to evolve as we conduct research and testing of particular aspects of the system design.**[1]

The Harvard-Common Good proposal starts from the point that America's medical liability system works poorly for both providers and patients. Substantial and growing malpractice insurance premiums strain physicians and hospitals, threatening access to health services in some areas. The system compensates few injured patients, and has very high administrative costs. As the Institute of Medicine has noted, it also adversely impacts healthcare quality, by discouraging reporting of information about errors and near misses in treatment.

Notwithstanding the substantial and well-documented failings of the current system, little political consensus for reform has developed. To the contrary, debate over medical malpractice reform remains very polarized, with most Republicans vocally calling for caps on noneconomic damages and most Democrats equally vocal in protesting that caps will hurt injured patients. Fresh policy approaches to malpractice reform are needed, and health courts offer a new, bipartisan approach.

ELEMENTS OF THE HEALTH COURTS PROPOSAL

As currently envisioned, health courts would include the following:

• **Trained judges** with expertise in adjudicating medical malpractice disputes. These judges would consult with neutral medical experts to determine the standard

[1] The Harvard School of Public Health and Common Good are conducting this work during 2005–2006 with the support of the Robert Wood Johnson Foundation, the Commonwealth Fund, and the Harvard Program on Health System Improvement.

of care in medical injury cases. Health court judges would issue written rulings of their decisions.

• **Compensation decisions** based on "avoidability," a standard that is broader than negligence but does not approach strict liability. In essence, injuries would be compensated if they could have been avoided if care had been provided according to best practice. This differs from the negligence standard, which focuses on whether care fell below customary practice.

• **Evidence-based guidelines to aid decisionmaking.** Medical experts and key stakeholders would review the best available scientific evidence about how adverse events occur and the extent to which they are preventable, and develop compensability recommendations for health court judges to apply. Clear-cut cases would be fast-tracked for compensation, and efforts would be made to encourage early offers of compensation.

• **Predictable damages** paid to claimants. A schedule of noneconomic damages would specify a range of values for specific kinds of injuries.

• **Patient safety improvements** facilitated by the system. Information from the adjudication process would be made available for root cause analyses, and standard event reporting would facilitate development of preventive practices.

KEY DESIGN CHOICES

State policymakers interested in implementing health court pilot projects face a number of design choices with respect to jurisdiction, selection of judges and experts, and a range of other issues. The following table summarizes the most significant of these choices, and offers the current Harvard-Common Good recommendation.

Design Choice	Options	Current Recommendation
Jurisdiction	1. Federal mandatory system 2. Statewide mandatory system 3. Voluntary, insurer-based state demonstration project. 4. Possibility of covering medical malpractice claims, or broader scope of coverage.	A voluntary demonstration project covering only medical malpractice claims will likely be most feasible. Federal demonstrations through Medicare may also be possible. Claims involving obstetrics and anesthesia may be particularly appropriate starting points for demonstration projects.
Decisionmakers and Experts	1. Expert panel at the involved hospital or insurer, operating under regulatory oversight. 2. Administrative law judge supported by independent medical experts. 3. State-appointed judge with medical expertise. 4. A combination of the above	Resolution of claims should begin with an internal review at the involved hospital or insurer by an expert panel using decision aids and schedules to make early offers of compensation. If the internal review did not lead to resolution, then an administrative law judge would make the determination in the health court, assisted by neutral experts with appropriate expertise.
Compensation Standard	1. Strict liability: all treatment injuries are compensated. 2. Avoidability: injuries are compensated if they were caused by treatment (or lack of treatment) and they could have been avoided had best practices been followed.	The avoidability standard is desirable because it reduces the emphasis on individual fault and acknowledges the role of system failures in contributing to injuries. To help define avoidable events, experts will generate a series of ''accelerated-compensation events'. Compensation decisions will be recorded in a searchable database that health court judges can refer to in future cases.
Claims Process	1. Administrative review of relevant documents. 2. Live hearing 3. Combination of the above	Many cases will be deemed eligible for compensation based on an administrative review of the medical record. Disputed cases will proceed to a live hearing, similar to an administrative law hearing. Claimants may, but need not, be represented by an attorney.

Design Choice	Options	Current Recommendation
Damages	1. Based on past jury awards 2. Scheduled	Economic damages will be paid in full. Non-economic damages should be limited to maximize the predictability of the system and contain costs. Non-economic damages will be paid according to a schedule tied to severity of injury and based on decision science research about utility losses and public deliberation about reasonable compensation. Collateral source offsets and restrictions on subrogation will also help to control costs.
Appeals	1. Judicial review if health court judge's decision was ''arbitrary and capricious''. 2. Judicial review based on ''substantial evidence'' standard.	A high standard of review—such as the ''arbitrary and capricious'' standard—will be cost-minizing and consistent with the standard used in other appeals of administrative agency decisions.
Financing	1. Financed through general tax revenues (social insurance model). 2. Financed through existing private insurance arrangements, with state assistance for start-up and administrative costs.	Financing through the existing insurance system with state assistance for start-up and administrative expenses will likely be most desirable. With experience rating, strong incentives can be provided for organizational safety improvement. Fees paid to attorneys representing claimants should be based on a multiple of hours worked rather than a contingency.
Relationship to Patient Safety Initiatives.	1. A single agency processes claims and is responsible for patient safety. 2. De-identified information from the adjudication process is shared with patient safety regulatory bodies, research entities, and quality initiatives, including JCAHO, NCQA, Leapfrog, and others. 3. Claims information is provided to hospitals. 4. Drug/device information is shared with the FDA..	Each of these elements are desirable.

For more information about the health court proposal, please contact Paul Barringer at Common Good [*pbarringer@cgood.org*, or 202-483-3760, x11].

HEALTH COURTS PROPOSAL SKELETON (VERSION DATE: 10/17/05)

CORE PRINCIPLES

1. Compensation decisions are made outside the regular court system by trained adjudicators. An explicit record of decisionmaking is kept in order to provide greater clarity in key areas (for example, expected levels of compensation, what constitutes acceptable/optimal care) to improve reliability of decisionmaking.

2. Compensation decisions are based on a standard of care that is broader than the negligence standard, but does not approach strict liability.

3. Compensation criteria are "evidence-based," in the sense that they are grounded in experts' interpretations of the leading scientific literature. To the maximum extent feasible, compensation decisions are guided by *ex ante* determinations about the preventability of common medical adverse events made through a process of deliberation and review of scientific evidence involving clinical experts and other key stakeholders. Certain kinds of injuries would be "fast-tracked" for expedited compensation.

4. Guidelines for compensating both economic and noneconomic losses are created for the system and applied to each claim that is judged eligible for compensation. Valuations of noneconomic damages are made using methods that are explicit, rational, and consistent.

5. De-identified information from the adjudication process is made immediately available to caregivers for root cause analysis and development of preventive practices. Information is also extracted from standardized event reporting for epidemiological analysis to understand new prevention strategies.

KEY DESIGN CHOICES

1. *Jurisdiction.* Define the range of covered disputes, including the scope of the demonstration project (government versus institutionally based; all clinical areas or select clinical areas) and the mandatory or voluntary nature of the system.

2. *Decisionmakers and the role of experts.* Explore qualifications for "judges" and possible appointment processes. Explore methods for using rulings on standards of care and compensation to provide guidance to stakeholders going forward. Consider merits of designated panels of experts from which judges can draw in each case. Define qualifications for experts, possible compensation structure, and appointment process.

3. *Claims process.* Critically review the experiences of other compensation systems, including procedural and structural methods for increasing efficiency and reducing administrative costs. Understand the method of disclosure used in countries with existing administrative systems for medical injury compensation. Outline possible streamlined procedures and timetable to final decision. Design appropriate notice and consent procedures for patients covered by the system.

4. *Compensation standard.* Define and operationalize the compensability standard. To the extent possible, pre-designate common adverse events as compensable or noncompensable based on expert consensus.

5. *Damages.* Select structures for determining economic and noneconomic damages.

6. *Appeal.* Determine the scope of appeal rights and possible structures for hearing appeals of the administrative health court's decisions.

7. *Financing.* Determine how the system, including administrative costs and claims costs, will be funded. What relationship will it have with existing forms of liability insurance and the institutions that write this insurance?

8. *Relationship to other patient safety structures.* Integrate the system with other structures designed to promote patient safety, in particular with hospital and medical group efforts to undertake root cause analyses, and State or Federal reporting facilities to identify epidemiological insights into patient safety. As well, outline the future roles for the State medical licensure boards, and the National Practitioner Data Bank.

PROPOSALS AND ALTERNATIVES

1. Jurisdiction

a. Administration

Alternatives.—(1) Federal mandatory system; (2) Statewide mandatory system; and (3) State demonstration project with voluntary participation of one or more liability insurers or hospitals.

Current recommendation.—A voluntary demonstration project is probably most feasible as a starting point, although the possibility of a Federal demonstration through the Medicare program is also worthy of exploration. To some extent, political factors will determine the choices made on this dimension of system design. At this point, there might be some interest in a Medicare program that would serve all Medicare beneficiaries. Alternatively, the Congress might make funds available for a State demonstration. States will likely be more comfortable with an approach in which insurers/provider organizations elect to participate, rather than one in which participation is mandatory statewide. This is the approach chosen by the inter-governmental working committee in Pennsylvania currently exploring the feasibility of a pilot administrative compensation program.

b. Covered Disputes

i. Nature of Claims

The demonstration project would cover ordinary medical malpractice claims only. Intentional tort claims, medical product liability claims, and mixed coverage/treatment claims against managed care organizations would remain in the jurisdiction of the tort system.

ii. Clinical Areas

Alternatives.—(1) All clinical areas; (2) Select clinical areas such as obstetrics and surgical/anesthesia.

Current recommendation.—If a demonstration project approach based on voluntary participation is chosen, it would be possible to start with just a few clinical areas in which the types, range, and causes of adverse outcomes are relatively well understood. Ideally, we would also like clinical areas that allow prospective consent on the part of the patient, as the patient will have to be offered the opportunity to participate. Anesthesia and obstetrics make the most sense based on these two parameters. The claims arising from these two areas are relatively homogeneous, and in many cases, there is ample time before the event in which providers can seek informed consent from the patient to participation in the demonstration project.

However, if an entire State, or the national Medicare system, opts for a mandatory approach, it is probably not useful to start with a partial approach, given the problem of boundary disputes.

2. Decisionmakers and the Role of Experts

Alternatives.—(1) A panel of medical and/or claims experts at the involved hospital or insurer, operating under State oversight and with discretion constrained by a legislative mandate to apply pre-established decision aids and damages schedule; (2) An administrative law judge who has no medical training, but who specializes in the adjudication of medical injury claims, and who is supported by independent medical experts; (3) A state-appointed judge with medical expertise; and (4) A combination of #1 with #2 or #3.

Current recommendation.—The first level of review would be an internal process at the involved hospital or insurer. This level of review is not intended to be a neutral adjudicatory process, but rather a formal mechanism for encouraging expeditious settlement of claims. A panel of experts convened by the involved hospital or insurer would review the event and, using decision aids and schedules make an early offer of compensation within 4 weeks. This would be done in concert with disclosure of the event by the caregivers. Counseling for patients would proceed along the lines developed by the insurer COPIC (the "3-R's" program) in an effort to resolve as many claims in this early stage.

If the early offer did not lead to resolution, then a health court hearing would be held on a prompt basis. As described in option 2 above, an administrative law judge who specializes in health court claim adjudication would be assisted by medical experts with relevant expertise who come from a panel constituted through volunteers or selection by the court.

3. Claims Process

a. Locus of the System

Alternatives.—(1) Statewide, mandatory system; (2) Voluntary, insurer-based program.

Current Recommendation.—This will be a political decision. A statewide program would have fewer boundary issues, but would likely be difficult to gain approval in a State legislature at present. The latter would involve individual hospitals, or care systems, opting into the program, along with their insurer (likely self-insurer) in an enterprise liability format. We outline both below in detail in **Appendix 1**.

b. Claimant Rights

Claimants would have full access to their medical records and the right to be represented by an attorney, though representation would not be needed in many cases as the health court process would be consumer-friendly in design. The opinion of the hospital or insurer panel at the first stage of review would also be part of the claim record available to the claimant. Claimants would also have a right of appeal as described in Section 6.

In the context of a system in which an initial decision about a claim is made by the involved hospital or insurer, patients should have access to any materials used in a peer-review investigation (as they do under current law). In addition, since any peer-review committee report would likely influence the decision made on the claim, patients should also be able to access any sections of such a report that relate to their own injury (a limited reduction in peer-review protection as compared to present law).

4. Compensation Standard

a. Liability Rule

Alternatives.—(1) Strict liability for defined treatment outcomes that are shown to be causally related to medical management; (2) Avoidability, as determined by a general definition plus lists of accelerated-compensation events (ACEs).

Current recommendation.—The notion of avoidability seems to be the best choice. This criterion could be modified by additional criteria based on the injury's severity, its rarity, or a focus on particular types of outcomes (e.g. birth injuries).

Avoidable events are injuries that are caused by treatment (or omission of treatment) and that could have been avoided had care been provided according to best practice. In other words, an injury is deemed avoidable if it might have been prevented had a better system of care been in place. The decision as to whether the injury is avoidable is made in light of the circumstances as known at the time care was delivered.

To help define what events will be avoidable, a series of ACEs will be generated. The ACEs lists will describe injuries that are automatically deemed avoidable based on strong *ex ante* inferences about the relationship between the treatment-outcome pair. Events that match the specifications and clinical circumstances of an item on an ACE list would be eligible for expedited compensation. The ACE lists would be developed by an expert consensus process, relying on the best available evidence.

The concept of avoidability occupies a middle ground between the concepts of strict liability (in which all injuries caused by medical care are compensable) and negligence (in which only those events due to provider fault are compensable). To obtain compensation, claimants must show that the injury would not have occurred if best practices had been adhered to, but they need not meet the more exacting negligence standard and show that a defendant acted as "no reasonable practitioner" would have.

The avoidability standard is desirable because it moves away from the notion of individual fault and the negative connotations that the medical profession associates with negligence. It comports with the notion of preventability, which is critical to the patient safety movement's insistence on lack of blame. But it does not have the onerous financial implications associated with a move to strict liability. We recognize that delineating avoidable from unavoidable events will not be straightforward in all situations. However, the negligence distinction itself is not clearcut. Moreover, compensation systems abroad have successfully made the avoidability/unavoidability distinction in thousands of cases. In addition, the use of accelerated-compensation events will facilitate appropriate decisionmaking.

b. Use of Guidelines

The system would incorporate guidelines and precedent by:

- Recording compensability determinations made by the administrative panels in a written decision and compiling decisions into a searchable electronic database that can be accessed by adjudicators in future cases involving similar injuries.
- Preparing lists of accelerated-compensation events based on expert reviews of the best available medical evidence about injury causation, frequency, and preventability.

Current Recommendation.—Both developments are critical to an efficiently functioning compensation system.

5. Damages

a. Economic Damages

Economic damages would be compensated in full except:

- There might be a deductible period or out-of-pocket amount (we suggest that eligibility begin when patients reach 4–6 weeks lost work time or $3,000–$4,000 in medical expenses).
- Payments would be made on a periodic basis.
- Awards that include a future loss component would be re-examined every few years.

Methods for valuing the different components of economic losses would be based on those used in the tort system. The valuations would be made by an expert employed by the decision panel, based on information provided by the plaintiff. As outlined above, the insurer/hospital would be subject to a financial penalty if it did not make a damages assessment in good faith, with such a breach being determined by reference to the extent of divergence insurer/hospital's offer and the valuation subsequently made by the independent expert.

b. Noneconomic Damages

First, a matrix of levels of injury severity would be generated, based on one of the following:

1. National Association of Insurance Commissioners' 199-point disability scale;
2. AMA Guides to the Evaluation of Permanent Impairment;
3. Decision science research about utility losses associated with different health states; or
4. Any of the above scales plus age categories.

Second, a dollar value range would be assigned to each cell in the matrix. The adjudicator would select a value in the range depending on the specific facts of the case compared to other like cases.

Alternatives.—(1) Values based on jury verdict data, with or without an existing statutory cap.

(2) Values based on public deliberation about (1) reasonable compensation for the various levels of noneconomic loss; and (2) what the maximum total costs of the compensation system should be.

Current Recommendation.—Values should be based on decision science research about utility losses and public deliberation about reasonable compensation. Academic research into utility valuations can be used to inform public deliberation.

c. Subrogation

Alternatives.—(1) Defendants in health court demonstrations pay the full damages award and third party payers (e.g. health or disability insurers) may exercise rights of subrogation. (2) Defendants serve as secondary or tertiary payers paying the balance of damages after contributions by collateral sources, and subrogation rights may not be exercised by third party payers.

Current Recommendation.—Collateral source offsets and restrictions on subrogation activities will help contain the costs of a health court demonstration. Statutory amendments at the State level and possibly also at the Federal level will be required, however, to preserve defendants' status as secondary or tertiary payer. This is because Medicare and Medicaid both enforce second payer rules of their own, and the Employee Retirement Income Security Act may limit the ability of States to place first-payer mandates on employment-based insurance plans.

6. Appeal Standard

Alternatives.—(1) Judicial review based on "arbitrary and capricious" standard. (2) Judicial review based on "substantial evidence" standard.

Current Recommendation.—The judicial review is not intended to be a *de novo* review. Anything but a rather high standard for review would lead to large lawyering costs at the appeal level. Therefore, we recommend an "arbitrary and capricious" standard for review from the ALJ/appointed expert health court.

7. Financing

a. System Financing

Alternatives.—(1) Social-insurance model financed through tax revenue from individual and/or corporate taxes. (2) Privately-financed model utilizing existing insurance arrangements plus an annual surcharge to the State to finance the administrative costs of the system. An initial public appropriation would be required to cover the costs of getting the system up and running.

Current Recommendation.—Privately-financed model with modest annual surcharge for State administrative expenses. As noted above, the financing would be based on an experience-rating system that gives sharp incentives for improvement.

The participants would likely make participation contingent on some protection against major losses in the early years of a demonstration project. From an actuarial standpoint, the avoidability standard will create an element of uncertainty that would limit voluntary participation, especially if there were insufficient numbers of participants to provide actuarial stability. Some type of stop-loss guarantee from a re-insurance entity will be a key issue in securing liability insurers' participation.

In a voluntary demonstration, large self-insuring systems might choose to go wholly over to the new approach and underwrite based on the avoidability standard. Commercial malpractice insurers might need to set up a subsidiary to accommodate hospitals and physicians interested in participating in the demonstration.

b. Attorney Fees

Because the health court system will be quicker and more efficient, attorneys fees should be based on a multiple of hours worked rather than a fixed percentage. This

is fair to lawyers and will result in patients keeping a much higher proportion of the damages.

8. Relationship to Other Patient Safety Structures

Alternatives.—(not mutually exclusive) (1) Create a single State (or Federal) agency, the Administrative Compensation Agency (ACA), which would have responsibility for both claims processing and fostering safety improvement activities. (2) Share de-identified claims data compiled by the ACA with other patient safety regulatory bodies, including State offices of patient safety and the Joint Commission on Accreditation of Healthcare Organizations, and research organizations; and purchasing/quality initiatives such as the Leapfrog Group and NCQA. (3) Share identifiable claims data organizations with responsibility for physician discipline, licensure, and certification. (4) Feed information on claims back to patient safety offices at hospitals. (5) Share drug- and device-related information with the FDA.

Current Recommendations.—We suggest a combination of points #1, #2, #4, and #5. We would suggest that the hospitals share de-identified claims data with external patient safety organizations such as the JCAHO. We would recommend that the State fund a claims database with standard reporting and data fields which would facilitate epidemiological analysis of the claims data by approved researchers. Either a local staff, or experts identified through grants, would analyze the data for new prevention strategies. We recommend that the State fund at least a modest health court administrative staff to maintain the database, liaise with researchers around data requests, and disseminate analytical findings to hospitals and other healthcare providers.

Information would also be fed back to patients safety teams at each place of original occurrence so that they could undertake root cause analyses at the same time that patients were being informed. This marries the notion of disclosure to full information.

Additional specific recommendations include the following:

• *Patient safety activities.*—In addition to relaying critical and relevant information to the appropriate agencies, the health court system administrative staff may undertake its own patient safety improvement activities. Many of the current regulatory or research organizations working to improve patient safety often can issue only recommendations regarding best practices. In certain instances where a more immediate benefit to patient safety and welfare may be gained, consideration can be given to providing the health court with the ability to require remediation or improvement in an underlying contributing factor. Health court mandates for remediation or improvement would be taken without placing blame on an institution or provider and generally kept confidential. Disclosure would be made only in circumstances of egregious patient harm or if there is a failure to comply with a health court request. Potential patient safety activities are provided.

• *Database maintenance.*—For purposes of patient safety, the health court administrative staff would maintain a database of all claims filed and all claims paid. With the presence of proper patient incentives for reporting, this database could serve as a repository for information of all medical injury for covered providers. This database would be searchable (many fields would be predetermined), permitting epidemiological research and periodic reports on medical injury.

• *Medication- and device-related events.*—The health court administrative staff would be able to monitor for claims related to medications and devices. Whether paid or not, claim patterns may provide early warning on the dangers of medications and devices. If related to specific products, notification could be provided to the FDA.

• *Egregious professional misconduct.*—In cases of egregious provider misconduct, in which the health court determines that a risk of significant harm continues to exist for other patients or that this event was clearly outside of the bounds of professional behavior, the health court may opt to notify the appropriate regulatory, disciplinary, or licensing agency. Because the intent of this system is to keep compensation decisions separate from decisions of responsibility and blame, disclosure would be permitted only in narrow circumstances where the danger to patient safety is clear, ongoing, and significant.

• *Providers with multiple paid claims.*—It may become apparent to the health court that a certain provider (entity or person) has a pattern of claims or repeated injury. In these circumstances, the health court administrative staff may undertake an independent investigation by reviewing all of the claims made. If the investigation determines that the pattern rises to the level of egregious professional misconduct, action may be taken as described above. If the pattern of injury does not rise to that level, but demonstrates a need for further training or, in the case of an entity, correction of a certain practice or risk, the health court may order such

remediation. Reporting will not be made to a disciplinary or regulatory agency unless the provider fails to comply with a request. Fines may also be issued for repeated injuries for which the provider has been on notice and has had sufficient time to remedy a contributing factor.

• *Nosocomial infections.*—Due to patient incentives to file claims, the health court administrative staff may be able to more readily gather rates of nosocomial infection with significant patient adverse outcomes. To encourage reporting of infections, the health court could provide automatic or scheduled compensation for certain types of infections which are considered highly preventable. If repeated patterns are noted within a provider, action may be taken as described above.

• *Prioritization of patient safety measures.*—The health court may help overcome the problem of prioritizing patient safety measures. During investigations, questions regarding which specific patient safety practices may have prevented the injury may be asked. Practices could be taken from Leapfrog measures, NQF measures, AHRQ practices, or JCAHO patient safety standards. Based on the data gathered, recommendations could be made to individual institutions. These recommendations may come with deadlines for implementation.

• *Provider-specific information.*—At the request of a healthcare organization, the health court administrative staff may provide detailed claim and compensation information of that organization compared with that of all other claims. This would permit large organizations to initiate improvement activities in specific areas and to learn from organizations with lower rates of injury.

• *Periodic publications.*—The health court administrative staff may periodically publish de-identified claims information for the benefit of the public, researchers, providers, and/or payors. Some examples are types and rates of injuries reported and percentages compensated; relationships between volumes and rates of compensated injury at medical centers; and rates of unexpected deaths.

APPENDIX ONE: DETAILED CLAIMS PROCESS

STATEWIDE, MANDATORY SYSTEM (FIGURE 1)

1. When an adverse event occurs, the hospital makes an initial determination whether the event falls within the class of adverse events covered by the system. If so, the hospital is required by State law to notify the patient and/or family of their right to seek compensation under the system.

2. The patient or family files a claim with the hospital by completing a simple form describing from their own perspective what happened. Such forms are widely available at the point of care, and displayed prominently. They have the option of involving legal counsel if they wish, and they have the right to review their medical records.

3. The hospital is required to notify the health court system that it has received a claim within the system's jurisdiction.

4. The hospital has responsibility to make an initial determination on the disposition of the claim. An expert panel convened by the hospital renders a judgment on the compensability of the event and with claims adjusters' advice, makes an offer. This internal review is not intended to be a neutral adjudicatory process, but rather a formal mechanism for encouraging expeditious settlement of claims. The decision-making process is guided by pre-established decision aids, including a definition of avoidability and a compendium of accelerated-compensation events that carry a presumption of avoidability. There are three possible outcomes of the expert panel's decision: (1) clearly compensable; (2) clearly not compensable; (3) uncertain compensability. The claimant receives a written report from the panel including an explanation of its reasons for decision, and has the right to review the documents the panel consulted in reaching its decision.

5. If the hospital panel judges the claim to be clearly *compensable*, the hospital makes an offer of compensation. The panel's determination of the amount of compensation is guided by a schedule of damages.

6. If the patient/family feels that the hospital did not correctly apply the damages guidelines or failed to take into consideration some factor in their case that affected damages, they may request a redetermination of damages from the health court. If the health court finds that the hospital had made a clear error in applying the damages guidelines, it may assess a financial penalty on the hospital, in addition to awarding the patient/family the correct amount of damages.

7. If the claim is judged to be clearly *not compensable*, the patient/family has the option of appealing the hospital panel's decision to the health court. The health court consists of an administrative law judge assisted by court-appointed experts, and is intended to be a neutral adjudicatory process. The health court reviews the

claim *de novo* using all available materials and a process similar to that of the hospital panel. The health court holds a live hearing. Basic but relaxed rules of evidence are observed, similar to an administrative law hearing. The involved clinicians and the patient appear and present information. The panel may invite experts to give opinions in person or in writing. Patients and the providers may be represented by counsel.

8. The same process occurs if the initial decision is that the case is judged to be of uncertain compensability in the first stage. The health court evaluation in this situation is automatic, and is not conditioned on the patient's decision to appeal.

9. If the health court judges the event to be compensable, it assesses damages using the same guidelines as the hospital panel. It issues a written explanation of its reasons for decision which is provided to the parties. If the health court overturns the hospital's decision and makes a finding that the case was clearly compensable, it may impose a financial penalty on the hospital. (A penalty would also be imposed if it came to light that the hospital or its healthcare providers failed to disclose information known about the injury to the patient/family.)

10. The patient/family may appeal an adverse determination of the health court to a judicial court, which would apply a deferential standard of review. The claimant has the right to review the documents the health court consulted in reaching its decision.

11. If the final determination in the case is that the patient/family is entitled to compensation, the payments are made out of a provider-financed, state-administered compensation fund on a periodic basis. The final disposition of the case is recorded by the health court administrative staff and all written decisions in the case stored in health court's database. A health court administrator has responsibility for periodically contacting the patient/family to query whether any adjustment to compensation for future medical expenses, rehabilitation, custodial care, home care, or other expenses is required due to unforeseen circumstances. The patient/family may also apply for such an adjustment directly.

12. An experience rating system is used for determining hospital contribution to the health court system.

VOLUNTARY, INSURER-BASED DEMONSTRATION (FIGURE 2)

1. The State passes authorizing legislation establishing the compensation system as the exclusive legal remedy for patients who suffer medical injuries that are covered by the demonstration. The statute has detailed requirements for notice and consent procedures for patients.

2. Pursuant to the statutory requirements, the participating hospitals or care systems compose informational materials for patients. The brochures describe how the system works, explain the advantages and disadvantages of the system from a patient's perspective, and inform patients that the system will be their only remedy if they decide to seek care from a covered provider. The brochures are widely available and prominently displayed in participating healthcare facilities. Patients are given a copy of the brochure at the time of first contact or whenever they seek care from a hospital or provider covered by the scheme.

3. The malpractice insurer for the hospital, doctor group or care system acts as the initial decisionmaker on claims, much as it does under the current liability system, although applying the new standard and compensation approach.

4. When an adverse event occurs, the hospital determines whether it falls within the class of events covered by the demonstration. If so, the hospital must report the event to the insurer and notify the patient or family of their right to seek compensation under the demonstration. Just as above, the provider group, supported by the insurer, would make an early offer. The insurer may impose a premium surcharge on the hospital and/or its health care providers if it comes to light that they failed to disclose information known about injury to the insurer or the patient in a timely fashion.

5. The patient/family files a claim with the insurer by completing a simple form describing from their own perspective what happened. They have the option of involving legal counsel if they wish, and they have the right to review their medical records.

6. The insurer submits the claim to its in-house panel of clinicians and/or claims adjusters to render a judgment on the compensability of the event. The decision procedures would be similar to those described above for the hospital panel. As above, this stage of review is intended to encourage settlement offers rather than serve as a neutral adjudicatory process. The claimant receives a written report from the insurer including an explanation of its reasons for decision, and has the right to review the documents the insurer consulted in reaching its decision.

7. If the insurer panel judges the claim to be *compensable*, the insurer makes an offer of compensation. The amount of compensation is determined with the aid of a schedule of damages. If the patient/family feels that the panel did not correctly apply the damages guidelines or failed to take into consideration some factor in their case that affects damages, they may request a redetermination of damages from the State health court. If the health court finds that the insurer panel made a clear error in applying the damages guidelines, it may assess a financial penalty on the insurer, in addition to awarding the patient/family the correct amount of damages. The insurer would pay a surcharge into a State fund that would be used to finance the administration of the health court.

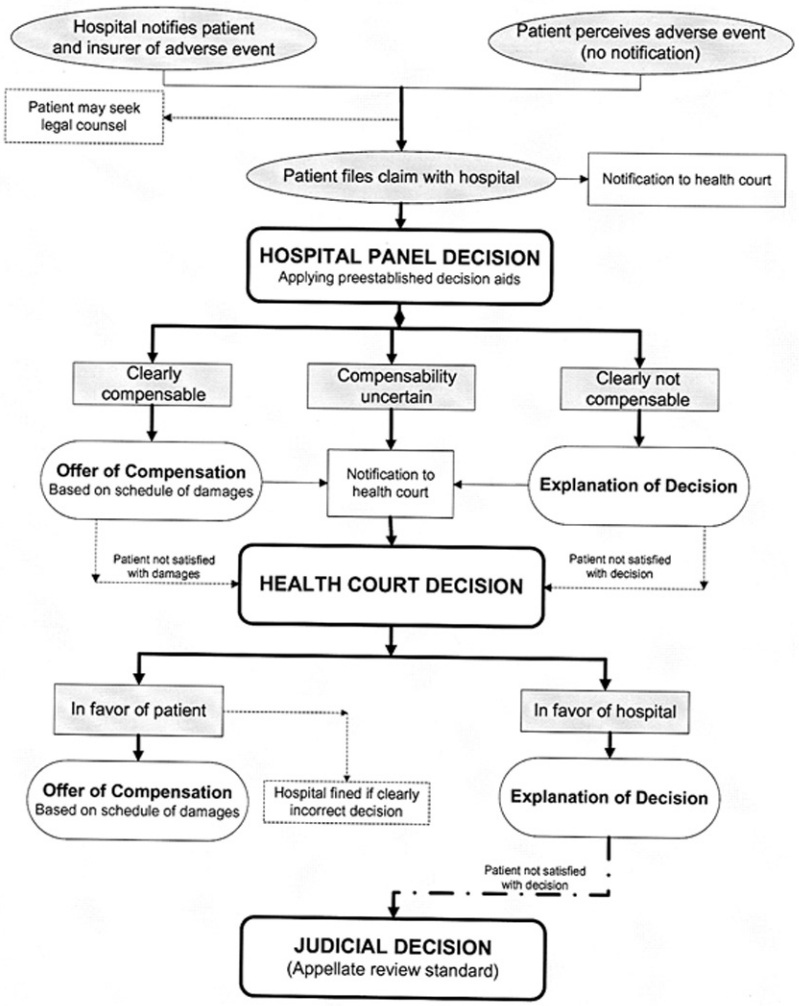
8. If the claim is judged to be *not compensable*, the patient/family is given an explanation of the decision. They have the option of appealing the decision to a State health court, which serves as a neutral arbiter of the dispute. The health court reviews the claim *de novo* using all available materials and a process similar to that of the insurer panel. A live hearing is held. Basic but relaxed rules of evidence are observed, similar to an administrative law hearing. The involved clinicians and the patient appear and present information. The panel may invite experts to give opinions in person or in writing. Patients and the providers may be represented by counsel. The health court issues a written explanation of its reasons for decision which is provided to the parties. If the health court judges the event to be compensable, it assesses damages using the same guidelines as the insurer panel. If the health court overturns the insurer's decision of noncompensability and makes a finding that the case was clearly compensable under the rules and compensation guidelines of the demonstration, this finding triggers a financial penalty for the insurer. The insurer would pay a surcharge into a State fund that would be used to finance the administration of the State health court.

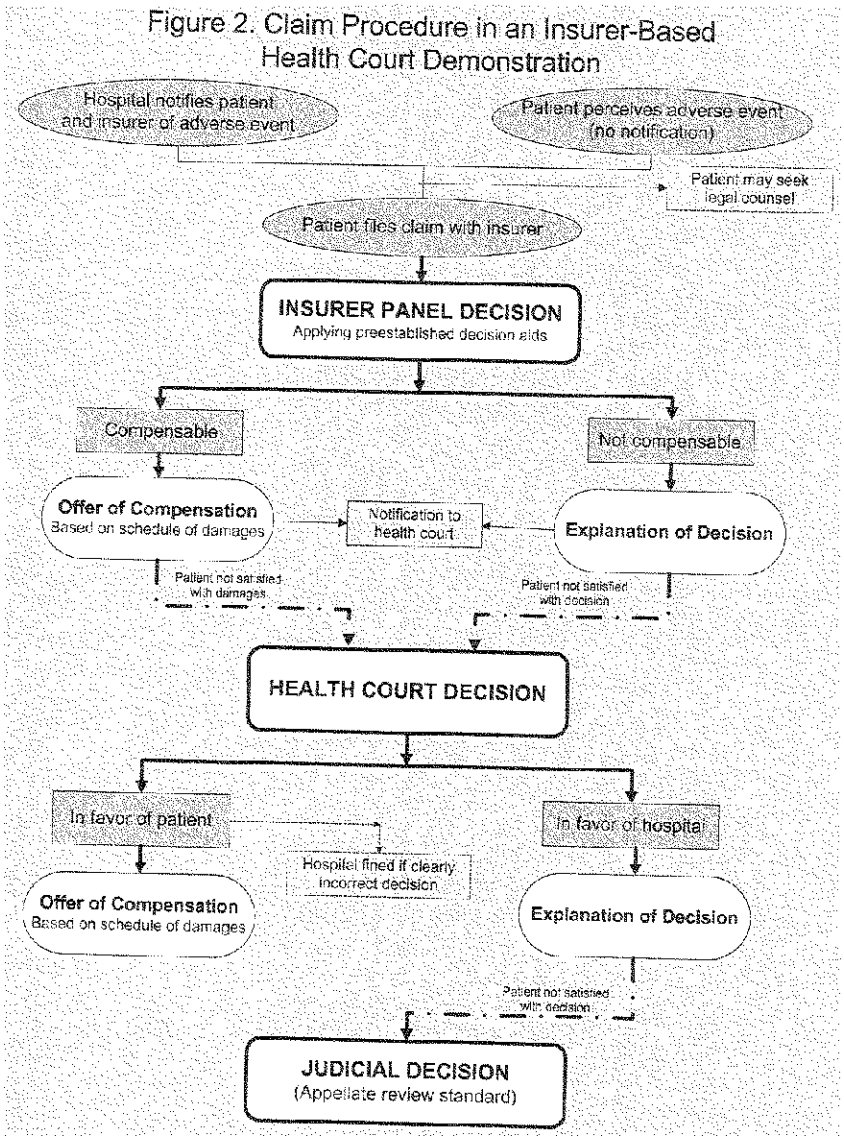
9. The patient/family may appeal an adverse determination of the health court to a judicial court, which would apply a deferential standard of review. The claimant has the right to review the documents the health court consulted in reaching its decision.

10. If the final determination is that the patient/family is entitled to compensation, they receive periodic payments from the insurer. The final disposition of the case is recorded in the health court database and all written decisions in the case stored in the database. An administrator at the insurance company, under guidelines and oversight from the health court, periodically contacts the patient/family to query whether any adjustment to her compensation for future medical expenses, rehabilitation, custodial care, home care, or other expenses is required due to unforeseen circumstances. The patient/family may also apply for such an adjustment directly.

11. Again, experience rating is employed in determination of premiums paid by participants to fund the system.

Figure 1. Claim Procedure in a Statewide Health Court Sytem





The CHAIRMAN. If all of you can summarize with efficiency, we will be able to have a shorter hearing. I appreciate all of the information you gave us. All of it will be included in the record, and as you can tell, we learn more from the record than we do from the actual oral transmission of the information. So, anything you can do to help condense would be very much appreciated.

Mr. Sage.

Mr. SAGE. Do you want to do Mr. Howard first, perhaps?

The CHAIRMAN. No, go ahead, Mr. Sage.

Mr. SAGE. Thank you, Mr. Chairman, members of the committee. I'm a law professor. I'm also a physician.

In 2002, when the third medical liability crisis of the past 30 years was declared, the Pew Charitable Trusts asked me to lead a project on medical liability research. That same year, the Institute of Medicine invited me to serve on its committee on Rapid Advance Demonstration Projects, for which I helped design some of the malpractice reform models included in S. 1337, which this committee is considering.

Four years later, political debate remains polarized, mainly over the desirability of caps on noneconomic damages and other traditional tort reforms. Despite the passage of time, advocates of these measures have attempted to sustain a crisis mentality, while their opponents have argued that the crisis is ending and that reform is unnecessary.

I do not believe this is a productive debate. There is an expression that aspiring surgeons learn in medical school and residency: all bleeding stops. What matters, of course, is whether the patient is still alive when the bleeding stops. Similarly, all crises end. In communities across the United States, healthcare providers and patients are struggling with the shortcomings of the medical liability system that go far beyond intermittent spikes in physician malpractice premiums. Many good ideas have surfaced, and some are being tested, but I believe Federal leadership is needed to stop the bleeding quickly and to heal the malpractice system so that gaping wounds will not reopen.

I'm greatly encouraged by this hearing, because the committee of the U.S. Senate with the most direct jurisdiction over healthcare is engaged with the malpractice system. To me, the greatest challenge for liability reform is that little connection has been made between the malpractice system and the healthcare system. Malpractice reform should begin with improvements in the processes of care that keep patients safe and in the ways that providers help patients deal with injury. Insurance mechanisms and legal standards are important, but I believe that malpractice reform should focus more on the bedside and less on the courtroom.

Current stresses to the malpractice system are the product of the tremendous success of modern medicine, not its failure. Technology has enabled physicians to detect and treat diseases earlier but also far more expensively. The bleeding in the malpractice system continues because it has not kept pace with these trends in medicine. Periodic malpractice insurance crises make liability seem epidemic to medicine when, in fact, it is endemic.

The existing system potentially compromises healthcare in this country for three principal reasons: first, there is a two-sided mismatch between negligence and the threat or event of litigation. Many claims turn out not to be justified, but rates of medical error are disturbingly high, and most avoidable injuries go uncompensated.

Second, the process for resolving medical injuries is simply appalling. Intimate bonds between patients and physicians are often shattered, with third party liability insurers regarding those who file claims as both strangers and adversaries. Information is routinely withheld, delays are extreme, and complex relationships are

reduced to dollars and cents. Healthcare providers are also victims. Isolation, fear, anger, and shame take a toll, while opportunities for learning and improvement are rare.

Third, conventional malpractice litigation and conventional malpractice insurance focus on individual physicians rather than the systems of care in which they practice. The Institute of Medicine made a compelling case for system-based safety improvement. To rely exclusively on individual physician accountability is to provoke gross misdeterrence, clinical responses to perceived risks of liability that fail to advance quality of care.

What are the paths to improvement? There is substantial consensus among academic experts that the United States should test comprehensive malpractice reforms. A better medical liability system would have two core elements: no-trial dispute resolution and a health system rather than individual physician focus. Initial dispute resolution processes would be a routine part of good clinical care. As in S. 1784, providers would make immediate disclosure of errors and would apologize when appropriate; mediated discussions would begin promptly, with providers offering compensation in all clearly eligible cases and transmitting information readily to internal patient safety improvement processes. Only the relatively few cases that cannot be resolved near the bedside would be referred to a formal administrative system of adjudication.

There are several avenues for testing reforms of this type, many of which are incorporated into S. 1337. In my opinion, the key is to associate malpractice reform with and thereby leverage existing regulatory and professional self regulatory organizations charged with protecting healthcare policy. Administrative health courts might be established under State agencies that regulate healthcare or patient safety through sponsorship of health coverage under ERISA, within governmental systems such as the Veterans Health Administration, or within the Center for Medicare and Medicaid Services, and I would like to emphasize in my written testimony the desirability of conducting some malpractice demonstration projects within the Medicare program.

I believe that testing reforms on a demonstration basis in a variety of settings is preferable to committing in advance to a single national model. Debates over comprehensive malpractice reform tend to get mired in the aggregate budgetary implications of potentially surfacing and compensating a greater number of claims. By testing reforms limited to particular providers and locations, sponsors could make the terms of reform attractive to patients, could hold providers harmless for the financial burden exceeding their current liability expense, if any, and could measure the actual costs and benefits to the participants in society.

Let me conclude by mentioning my father, Dr. Harold Sage, who is celebrating his 92nd birthday today, June 22. My father graduated from medical school in 1937 and retired from surgical practice about 20 years ago. He's alive today because of what medicine can do, but he has also been a victim of medical error. Now, the IOM, in its successor report to "To Err is Human" called upon the healthcare system to become safe, effective, patient-centered, timely, efficient, and equitable. I would argue that the existing medical malpractice system advances none of these goals.

Crises are definitional. The current malpractice crisis will end. Premiums will fall, and lawsuits may even drop. But errors are still frequent; compensation remains uneven; and the litigation process is unacceptable. Change is possible with Federal leadership, and for that reason, I ask you to help us stop the bleeding by supporting innovative demonstrations like S. 1337 and S. 1784.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Sage follows:]

PREPARED STATEMENT OF WILLIAM M. SAGE

Mr. Chairman and members of the committee, I appreciate the opportunity to speak with you about the role that medical liability reform can play in U.S. health policy. I am a lawyer and law professor. I am also a physician.

In 2002, when the third "medical malpractice crisis" in the past 30 years was declared, The Pew Charitable Trusts in Pennsylvania asked me to head a comprehensive Project on Medical Liability. The same year, the Institute of Medicine invited me to serve on its Committee on Rapid Advance Demonstration Projects in Health Care, for which I helped design the malpractice reform models included in S. 1337, the Fair and Reliable Medical Justice Act. Since then, I have discussed medical liability with physicians, patients, hospital administrators, lawyers, and others; I have planned and conducted empirical research on the performance of the medical malpractice system; and I have developed and evaluated possible solutions to the problems that have been identified.

Four years later, political debate remains polarized, mainly over the desirability of caps on non-economic damages and other traditional "tort reforms." Despite the passage of time, advocates of these measures have attempted to sustain a crisis mentality, while their opponents have argued that the crisis is ending and that reform is unnecessary.

I do not believe this is a productive debate. There is an expression that aspiring surgeons learn in medical school or residency: "All bleeding stops." What matters is whether or not the patient is alive and stable *when* the bleeding stops. Similarly, all crises end. In communities across the country, healthcare providers and patients are struggling with the shortcomings of the medical malpractice system, problems that go beyond intermittent spikes in physicians' liability insurance premiums. Many good ideas have surfaced, and some are being tested. But Federal leadership is needed to stop the bleeding quickly, and to heal the malpractice system so that gaping wounds will not open again.

MALPRACTICE REFORM AT THE BEDSIDE

I am greatly encouraged by this hearing, by the fact that the committee of the U.S. Senate with the most direct jurisdiction over American healthcare is engaging with the malpractice system. To me, the greatest challenge for medical liability reform is that, notwithstanding high public visibility, little connection has been made between the malpractice system and the healthcare system. Malpractice reform should begin with improvements in the processes of care that keep patients safe and in the ways that providers help patients deal with unanticipated injuries that occur nonetheless. Insurance mechanisms to reduce and spread the financial risks from these injuries are important, as are legal standards to frame and resolve disputes over the causes and consequences of injury. But malpractice reform should focus more on the bedside, and less on the courtroom.

An important insight is that current stresses to the malpractice system are the product of the tremendous success of modern medicine, not its failure. Technology has enabled physicians to detect and treat diseases earlier and more effectively than was the case during the first malpractice crisis of the 1970s, though also more expensively. Similarly, length and quality of life have improved for patients with chronic health conditions. To achieve these results, physicians frequently practice in interdisciplinary teams, and depend on increasingly sophisticated facilities and supplies. This process of industrialization has brought corporate skills, and corporate risks, into healthcare delivery. Public expectations of healthcare have risen accordingly, as have salvage costs if something goes wrong. All of these factors increase the likelihood of malpractice litigation and worsen its financial implications for physicians.

The bleeding continues because the malpractice system has not kept pace with these trends, in large part because medical liability tends to hold the attention of

policymakers only when problems surface in the cost or availability of physicians' liability insurance. In other words, malpractice insurance crises make liability seem epidemic to medicine, when in fact it is endemic.

The existing malpractice system potentially compromises access to healthcare, reduces its quality, and increases its cost for three principal reasons. First, there is a two-sided mismatch between actual negligence and the threat or event of litigation. Many claims turn out not to be justified, but rates of medical error are disturbingly high, and most avoidable injuries go uncompensated.

Second, the process for resolving disputes is appalling. Intimate bonds between patients and health professionals are often shattered, with third-party liability insurers regarding those who file claims as both strangers and adversaries. Information is routinely withheld, delays are extreme, and complex medical relationships are reduced to dollars and cents. Healthcare providers are victims as well. Isolation, fear, anger, and shame take a toll, while opportunities for learning and improvement are rare.

Third, conventional malpractice litigation, and conventional malpractice insurance, focus on individual physicians rather than the systems of care in which they practice. In *To Err is Human*, the Institute of Medicine made a compelling case for system-based safety improvement. To rely exclusively on individual physician accountability is to provoke gross "misdeterrence"—clinical responses to perceived risks of liability that fail to advance quality of care. Fear of harm to personal reputation and financial stress over insurability not only reduce responsiveness to patient injury should it occur, but also lead physicians to practice "defensive medicine" on a daily basis. This can manifest itself either as costly overtesting and overtreatment, or as unwillingness to accept challenging cases and "difficult" patients.

PATHS TO IMPROVEMENT

There is substantial consensus among academic experts that the United States should test comprehensive malpractice reforms that would remove most medical injuries from conventional tort litigation, and place them instead in a customized compensation system that is closely connected to real-time patient care and clinical quality assurance. Recent reform proposals draw on a rich literature of policy innovation that emerged from previous malpractice crises, including early offers in settlement, accelerated compensation events (ACEs), guidelines for appropriate damages, specialized tribunals, fault-based and no-fault administrative systems, and enterprise liability for hospitals or HMOs.

A better medical liability system would have two core elements: "no-trial" dispute resolution and a health system rather than individual physician focus. The phrase "no-trial" (rather than "no-fault") is used to denote procedures that are distinct from conventional litigation but that retain, and in fact strengthen, healthcare providers' legal accountability for error. Initial dispute resolution processes would be a routine part of good clinical care. Providers would make immediate disclosure to patients who have suffered unexpected harm and would apologize when appropriate. Mediated discussions with the patient or family would begin promptly, with providers offering compensation in all clearly eligible cases, and transmitting information rapidly to internal patient safety and injury prevention systems.

Only the relatively few cases that cannot be resolved near the bedside would be referred to a formal administrative system of adjudication. ACEs—lists of adverse outcomes that are almost always associated with error—would serve as a foundation for developing a system that keys accountability to compliance with scientific "best practices." Patients who suffer avoidable injuries would receive compensation for economic damages not covered by other sources, plus capped non-economic damages using a sliding scale that takes into account the severity and duration of injury.

There are several avenues for testing reforms of this type, many of which are incorporated into S. 1337. In my opinion, the key is to associate malpractice reform with, and thereby leverage, existing regulatory and professional self-regulatory institutions charged with protecting healthcare quality. Administrative health courts might be established under the auspices of State agencies that regulate healthcare or patient safety, through private employers acting as sponsors of health coverage under ERISA, within governmental systems of care such as the Veterans Health Administration, or within the Center for Medicare and Medicaid Services.

There is also a role for private healthcare standard-setting bodies in malpractice reform. The Joint Commission on Accreditation of Healthcare Organizations, for example, could require hospitals to improve their error detection, disclosure, and dispute resolution processes. According to a 2005 JCAHO White Paper, a well-functioning liability system would assure (1) prompt disclosure of medical errors to injured patients, (2) apology, (3) analysis of the error to inform future prevention ef-

forts, (4) an early offer of compensation for losses, and (5) alternative dispute resolution to bring disputed claims to a swift, fair, and efficient conclusion.

I would like to emphasize the desirability of conducting some malpractice demonstration projects within the Medicare program. Medicare policy often sets the standard for the healthcare system generally. Medicare is experienced at sponsoring demonstrations of health policy innovations. Medicare is essential to the hospital sector, and can foster voluntary enterprise liability within those institutions. Medicare already operates contractor-based and external systems of medical review, and utilizes an administrative law model for resolving disputes over benefits that raise similar issues of disability and valuation of injury. Medicare can connect malpractice claims to consumer information, quality improvement, and patient safety through various ongoing initiatives. Medicare is a pioneer in pay-for-performance, which could include financial incentives to respond effectively to unanticipated injury. Finally, conventional malpractice litigation is unavailable or unattractive to many Medicare beneficiaries, making their voluntary participation in experimental reform more likely.

I believe that testing reforms on a demonstration basis in a variety of settings is preferable to committing oneself in advance to a single national model. The effectiveness of liability reform depends to a considerable extent on the clinical and administrative capacities of particular healthcare providers and on the reactions of both malpractice plaintiffs and malpractice defendants to changed incentives and procedures. For example, the Institute of Medicine recommended Federal funding of demonstrations involving hospitals and other institutional providers that meet safety-related criteria for participation and that could assure their patients of a prompt, compassionate response to unexpected injury.

Furthermore, debates over comprehensive malpractice reform tend to get mired in the aggregate budgetary implications of potentially surfacing and compensating a greater number of claims than currently attract the attention of plaintiffs' lawyers. Proposals for large-scale change that emerge under these constraints are often stacked against claimants in order to guarantee overall affordability. By testing reforms limited to particular providers and locations, sponsors could make the terms of reform attractive to patients, could hold providers harmless for any financial burden exceeding their current liability expense, and could measure the actual costs and benefits to the participants and to society.

CONCLUSION

Let me conclude by mentioning my father, Dr. Harold Sage, who is celebrating his 92nd birthday today, June 22. My father graduated from medical school in 1937. He retired from surgical practice about 20 years ago, and now experiences the healthcare system mainly as a patient. He is alive because of what modern medicine can accomplish, but he has also been a victim of medical error. And he understands that today's complex and expensive healthcare system requires careful governance, including with respect to medical liability.

The successor report to *To Err Is Human* called upon the healthcare system to become safe, effective, patient-centered, timely, efficient, and equitable. The existing medical malpractice system possesses none of these qualities. I often receive inquiries from physicians and hospitals asking if funding is available for the demonstrations that the IOM recommended in 2002. In Pennsylvania, for example, the hospital association has worked hard to develop a comprehensive reform program, but it lacks the financing needed to test it.

Crises are definitional. The current malpractice crisis will end: Premiums may fall, and lawsuits may even drop. *But* errors are still frequent, compensation remains uneven, and the litigation process is miserable. Yet change is possible with Federal leadership. Please help us stop the bleeding by supporting innovative demonstration programs like S. 1337.

The CHAIRMAN. Mr. Howard.

Mr. HOWARD. Thank you, Senator Enzi, and Senator Kennedy for holding these hearings.

I think it is extraordinarily important to change the frame of reference of the malpractice debate, as the other witnesses have suggested, from focusing just on capping damages to making the overall system of healthcare work better, including working better for injured patients.

For 4 years, we have been hosting public forums jointly with the AEI-Brookings Joint Center, and all constituents were represented in these hearings: professional groups, large consumer groups, patient safety experts, and such, and what we found is that while premiums have risen dramatically, as Senator Kennedy suggested, the overall cost of this was really quite small in the healthcare system.

But what we also found was that that was a symptom of a much worse disease in the healthcare system, which is that there was a distrust that is literally pervasive in healthcare. And this distrust has changed the way doctors in America and hospitals practice medicine. It has chilled professional interaction. It is sort of like an invisible wall not only between patients and doctors but between doctors with each other, because people are afraid to speak up and use their peripheral vision and say are you sure that's the right prescription, because they don't want to take legal responsibility leading to tragic errors.

It has contributed—I agree it is not the main cause of the rise in healthcare costs. However—we'll get back to that —it has contributed to the skyrocketing cost. Only last month, I had arthroscopic surgery on my knee. They said I had to have a preoperative exam. I said, "What's that?" And they told me what it was. I said, "Well, I just went through that 2 months ago at my annual physical; why don't we just use that?" No, we won't use it. "I'll waive the legal requirements," I said. "Any liability will be waived."

It cost $1,500, not to me, to my insurer, and it was bad for me. I had to go through all these exams all over again because of defensive medicine. They wouldn't accept even a legal waiver from me to do it. It is literally pervasive. And it also doesn't provide effective accountability against bad doctors. Go to licensing boards or the people who run hospitals. When they try to get rid of a doctor, what happens is the doctor threatens to sue, and there's generally a settlement, because people don't want to go through 5 years of litigation, and the settlement is generally to give that doctor one more chance or to let him slide out the side door to practice on some other patients who don't know what his record is.

It's also not effective for patients, as Professor Sage and Professor Studdert have said: "slow, expensive, and unreliable," and as Professor Sage has noted, in many jurisdictions, you can't even get a lawyer for a malpractice case unless it is worth several hundred thousand dollars, not because the lawyers are bad people but because it's just too expensive. It takes too many years to go through the process.

So we ask ourselves after six of these hearings over the course of a number of years what system would best promote safe, affordable healthcare and provide a fair compensation system, and what we arrived at were several principles: it needs to aspire to consistency. It needs to offer guidelines so that people feel accountable if they keep up with good practices, but they will be affirmatively protected if they do keep up with good practices. And it means to have a mechanism for us to learn from our mistakes, none of which the current system does.

Now, America, as Senator Cornyn suggested, has a long tradition of special courts in areas of complexity. In 1789, there were special admiralty courts. There are bankruptcy courts, tax courts, a number of administrative compensation schemes, of which the largest is the workers compensation system, which is different from this in a variety of ways but not so different in others.

We entered into a joint venture with the Harvard School of Public Health several years ago to try to develop and refine the idea and, again, work with all of the interested groups, and what we've come up with, and there are many ways to do this, is the idea of experimenting with a pilot project with a court system which would have the following key features: judges dedicated to resolving malpractice cases advised by neutral experts; parties could have their own experts as well, but you would have a neutral expert who is actually trying to do what he thought is best; with written opinions so that people can see what the standards of care are, and if there is an error, can appeal that written opinion, say this is wrong for those reasons; a liberalized standard of recovery: it is too hard for injured patients to recover now. If somebody goes into a hospital with pneumonia and comes out with a staph infection, they shouldn't have to prove any more. They ought to get paid.

And so, we have an avoidability standard; so, we believe in this system, many more people will recover with much lower costs. It will be quicker; there will be a requirement of transparency and penalties on providers if they don't open up their records when there's a problem.

And finally, there would be schedules of noneconomic damages, as virtually every other developed country in the world provides. And the reason for this is not because it's fair in the abstract, because no amount of money could compensate me or any of us for a tragic loss or an injury. It's because it dramatically turns down the heat on the process. It reduces the fear of providers. It reduces the sense that I might get rich by going all the way through the system and saying how much would you give to lose a leg or the like?

It provides horizontal equity among patients. Today, you know, 1 in 1,000 wins a huge verdict, and most people, again, as the studies show, get almost nothing. We think it's a fairer system to have it be scheduled depending on the injury, and again, I think that schedule should be changed from time to time and be determined by a base closing commission or the Institute of Medicine or someone like that so that it's trusted.

There's an understandable reluctance to change from what we are so used to, the jury system. But I would suggest that what we're proposing, first, is only pilot projects. Second, it's not giving up the right to sue. It's changing it. It's creating a new right to sue, which we believe the test project would show is fairer for injured patients as well as dramatically better for the system of healthcare.

Everyone knows that there's a looming crisis in healthcare, crisis of affordability, crisis in quality. Judgments need to be made to fix it: what's good care; what's not? What can we afford to provide? We cannot make those judgments, I submit, until we have a system of justice that's reliable to uphold them.

And so, going back to Professor Studdert and Professor Sage's point, the goal here is to try a pilot of a system that could be the foundation from which this body can begin to make choices to bring order to a healthcare system that is rapidly trending toward a kind of nervous breakdown in this country, where people can't afford it and no one trusts anyone else.

The reason—and I would just end by saying a broad coalition is behind us: many patient safety experts, the most prominent patient safety experts in the country; large consumer groups such as AARP have called for pilot projects. This is not the tort reform community. The providers support it as well, but this has been led by people who have not supported tort reform but are supporting a better system of healthcare.

Thank you very much.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Howard follows:]

PREPARED STATEMENT OF PHILIP K. HOWARD

SUMMARY

The debate over medical malpractice has focused on one symptom—the rise in insurance premiums—without addressing the underlying systemic flaws.

Distrust of justice is tearing at the fabric of American healthcare, chilling open professional interaction and causing doctors to squander billions in unnecessary tests and procedures. The distrust stems from the fact that justice today tolerates inconsistent results for similar conduct, and appears to be inaccurate in over a quarter of the cases. Nor does the system work well for injured patients: meritorious cases often take 5 years, and consume 33 percent–40 percent of the recovery in lawyers' fees.

Making the choices needed to fix American healthcare—improving quality, containing costs and providing predictable accountability—requires a reliable system of justice. That's why a broad coalition of consumer and patient advocates, as well as healthcare providers, have come together behind the idea of creating special administrative health courts. The goal is to create a system of justice reliable for patients and doctors alike, and to act as a foundation for other choices needed to bring order to American healthcare.

Defenders of the system cling to the orthodoxy that each case be tried by a jury. But America has a mounting crisis in healthcare, and the goal of law is to support society, not the other way around. There is also a flaw in the current orthodoxy: The core idea of the rule of law—that like cases be decided alike—is not satisfied when juries make decisions in an *ad hoc* manner without consistent legal rulings on standards of care. America has a long tradition of special courts for disputes needing consistency and special expertise—admiralty courts, bankruptcy courts, workers compensation systems, to name just a few—and special health courts fit squarely within that tradition.

Thank you for providing this opportunity to discuss alternatives to the current medical malpractice system.

I appear as the Chairman of Common Good, a not-for-profit organization founded in 2002 to advocate reforms to restore reliability to American law. We are bipartisan—for example, former Senators Howard Baker and Bill Bradley recently joined our Advisory Board—and derive most of our funding from private and public foundations (our largest funder is the Robert Wood Johnson Foundation). The proposal to do demonstration projects for administrative health courts, which I will discuss today, follows six public forums, hosted jointly with the AEI-Brookings Joint Center, and hundreds of meetings with affected parties. The proposal was developed and refined in a joint venture between Common Good and a team from the Harvard School of Public Health, led by Professors Troy Brennan and David Studdert.

Special health courts are intended not simply to provide a better dispute resolution mechanism, but to provide a foundation from which deliberate choices can be made to restore order to American healthcare. The current ad hoc system, in which cases are decided jury by jury, without guidelines or precedent, has contributed to

a debilitating distrust that makes reforming healthcare almost impossible. Special health courts, by contrast, can offer guidance on standards of care and the predictability needed for trust. It is almost impossible to contain costs, for example, until there is a system of justice that is trusted to reliably uphold the costs contained.

Key features of special health courts would include administrative judges dedicated to malpractice disputes, advised by neutral experts and providing written opinions; liberalized standards of recovery; an expedited process with incentives for providers to make "early offers"; scheduled noneconomic damages, depending on the injury; and a coordinated patient safety department to collect and disseminate important information. We believe special health courts could serve three goals: first, to eliminate the distrust of justice that impedes quality and contributes to skyrocketing costs; second, to provide affirmative incentives to improve the quality of care; and third, to provide a reliable, efficient and quick compensation system for patients injured by faulty care.

A broad coalition has come together calling for demonstration projects of administrative health courts. The coalition includes leading organizations devoted to patient safety and healthcare quality, including the Joint Commission on Accreditation of Healthcare Organization, many medical societies and physician organizations, including the American College of Physicians and the American College of Obstetricians and Gynecologists, large consumer groups, including AARP, large corporate providers and payers, and dozens of university presidents and medical school deans.

Six of America's leading hospitals announced today their strong interest in participating in a health court pilot project: New York-Presbyterian, Johns Hopkins, Yale-New Haven, Duke Medical Center, Emory University Hospital and Jackson Health System at the University of Miami.

Many of the organizations supporting special health courts have not been supporters of "tort reform." But they support this effort to restore reliability because the goal is not just to provide relief to physicians but to create a system that is reliable for doctors and patients alike. The proposal enjoys broad editorial support in publications including *USA Today*, *The Economist*, *Newark Star-Ledger*, the *Detroit News*, and the *St. Louis Post-Dispatch*, among others. The public also seems to like the idea: a Harris Interactive survey found that two out of three Americans support the creation of special health courts.[1]

Because this proposal involves a major shift, not only in how healthcare disputes are resolved, but in our approach to healthcare choices more broadly, we believe it is important to test and refine the concept. That's why we seek pilot projects. With the crisis in healthcare looming before our country, we hope that Congress will provide the authority and means to test this constructive approach to bringing order to healthcare.

The Context of Reform. The debate over medical liability reform has not focused sufficiently, in our view, on the relationship between the legal system and daily choices in America's hospitals. There is little dispute that America's healthcare system is suffering from ill health:

- While the system provides miracle cures admired across the world, it tolerates too many avoidable errors—causing upwards of 100,000 unnecessary deaths annually, according to the Institute of Medicine.[2]
- Accountability is inconsistent: inept doctors often keep their licenses while good doctors find themselves liable on baseless claims; 1 out of 4 baseless claims result in payment, according to a recent study by Professor Studdert and others in *The New England Journal of Medicine*.[3]
- Skyrocketing costs—now approaching twice that of other developed countries, with no better outcomes—make healthcare insurance unaffordable for 1 out of 7 Americans.[4]

In these key respects, American healthcare is, more or less literally, out of control. No one seems to have the capacity to make the choices needed to restore order or to reign in crippling costs.

The Effects of Law on Healthcare. The debate over liability has focused on the rise in malpractice insurance premiums, and whether noneconomic damages need to be

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[1] Poll, Harris Interactive, Inc., June 14, 2004, available at: *http://cgood.org/healthcare-reading-cgpubs-polls-7.html*.

[2] Kohn, Linda T., Corrigan, Janet M. and Donaldson, Molla S. Editors, Committee on Quality of Health Care in America, Institute of Medicine, *To Err is Human*, National Academic Press, 2000.

[3] Studdert, David M., et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine*, vol. 354; May 2006, p. 2029.

[4] Income, Poverty, and Health Insurance Coverage in the United States: 2003, U.S. Census Bureau Report, August 2004, available at: *http://www.census.gov/prod/2004pubs/p60-226.pdf.*

"capped." Doctors in certain specialties, such as obstetrics, desperately need relief. But the total cost of the malpractice system, about $28 billion, while huge, represents only about 1.5 percent of total healthcare spending.[5] If doctors' premiums were the only problem, surely we could come up with a solution. The debate has generated more heat than light, with each side arguing about the fairness either to doctors or to injured patients. A strong case can be made, as will be discussed shortly, that the current system is fair to neither.

The first goal of justice, however, is to provide incentives and conditions for a sound healthcare system. The important question is this: Does the system of justice promote patient safety and effective use of resources?

Without room for serious debate, the current system is destructive of both goals. Distrust of justice is nearly universal among physicians and other providers. The overwhelming majority of physicians (83 percent) and hospital administrators (72 percent) do not feel that physicians can trust the current system of justice to achieve a reasonable result if sued.[6] This distrust has led to a culture of defensiveness that diminishes quality, raises costs and corrodes human dealings throughout the healthcare system:

• *The effect of law on quality*. Many tragic errors occur, according to the Institute of Medicine and others, because doctors and nurses, fearful of legal responsibility, are reluctant to intercede when they suspect something is amiss. More broadly, distrust of justice is a powerful disincentive to reporting errors and near misses.

The theory of tort liability is that it encourages safer practices. But this doesn't happen in healthcare. Leading experts agree that the current malpractice system does a poor job of policing bad providers and promoting patient safety. Professor William Sage notes that "the malpractice system fails to send clear signals for quality improvement." [7]

• *The effects of law on healthcare costs*. "Defensive medicine"—the practice of ordering tests and doing other unnecessary activities—is nearly universal. Although the costs of defensive medicine are almost impossible to quantify—estimates range from a few tens of billions to over $100 billion—no person who has encountered the healthcare system has not experienced it.[8] I was not allowed to have minor surgery recently until I'd gone through a complete pre-operative examination, complete with chest X-rays and other tests, at a cost to my insurer of $1,500. This was basically the same exam I had undergone a few months before at my annual physical, but the hospital would not accept those results, or indeed, even allow me to waive any claim. This was $1,500 not available for some person who needed care. Nor is the

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[5] Tillinghast-Towers Perrin, "U.S. Tort Costs and Cross-Border Perspectives: 2005 Update," p. 20, available at: *http://www.towersperrin.com/tp/getwebcachedoc?webc=TILL/USA/2006/200603/2005_Tort.pdf*; Smith, Cynthia, et. al., "National Health Spending in 2004," *Health Affairs*, Vol. 25, Issue 1; 2005, p. 186–196.

[6] Poll, Harris Interactive, Inc., The Fear of Litigation Study—The Impact on Medicine, 2002, p. 39. available at: *http://cgood.org/healthcare-reading-cgpubs-polls-6.html*.

[7] Sage, William, "Medical Liability and Patient Safety," *Health Affairs*, Vol. 22; 2003, p. 26–36, available at: *http://content.healthaffairs.org/cgi/content/full/22/4/26?ijkey=f437af2d1c6ff94a693fl60a23e55bf82b3de843*.

[8] In a major study on the effects of liability reforms, researchers found that hospitals reduced their expenditures by 5 to 9 percent within 3 to 5 years after the adoption of such reforms without increasing bad outcomes, leading the authors to conclude that this 5 to 9 percent went toward defensive medicine tasks and procedures. Kessler, D. and McClellan, M., "Do Doctors Practice Defensive Medicine," *The Quarterly Journal of Economics*, May 1996, p. 386–88. The U.S. Department of Health and Human Services has estimated that the 5 to 9 percent figure amounts to $60 to $108 billion nationwide spent on defensive medicine each year. U.S Department of Health and Human Services, *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing our Medical Liability System*, July 24, 2002, p. 7. Although there may be disagreement about the actual cost of defensive medicine, there is overwhelming evidence that it is ubiquitous. For example, a 2002 Harris Interactive poll of physicians found that 91 percent of physicians had noticed other physicians ordering more tests that they would base solely on professional judgment of what is medically needed, and 79 percent reported that they themselves do this due to concerns about malpractice liability. Poll, Harris Interactive Inc., The Fear of Litigation Study—The Impact on Medicine, 2002, p. 9, available at: *http://cgood.org/healthcare-reading-cgpubs-polls-6.html*. A recent survey of specialist physicians as part of the Project on Medical Liability in Pennsylvania found that nearly all (93 percent) reported practicing defensive medicine. "Assurance behavior" such as ordering tests, performing diagnostic procedures, and referring patients for consultation, was very common (92 percent). Defensive practice correlated strongly with respondents' lack of confidence in their liability insurance and perceived burden of insurance premiums. Studdert, D.M., Mello, M.M., Sage, W.M. et al, "Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment," *Journal of the American Medical Association*, vol. 293, 2002, p. 2609.

cost just monetary—unnecessary tests reduce immunity and increase the chance of complication.

Hospitals have become a kind of slow motion zone where no choice is not accompanied by forms in triplicate and precautionary procedures and discussions that are tangential to the healthcare decision at hand. A pediatrician in Charlotte recently told me that on a routine visit of a healthy child he used to write three lines on the patient chart. Now he writes 20 or 30 lines describing all the things which indicate that the child is not sick. Multiply these procedures by over 3 million doctors and nurses, and you have a system that is unaffordable.[9]

Let me also acknowledge that legal fear is not the only driver of unnecessary tests and procedures. Hospitals can also make money on them. But not on my unnecessary physical exam (it was not provided at the hospital doing the surgery), or the extra lines on the pediatrician's patient chart, or, I suspect, with most decisions by dedicated professionals.

• *The effects of law on accountability*. All people, including doctors, make mistakes, and they should fairly compensate those injured. The most important accountability, however, is licensure—bad doctors shouldn't be allowed to continue practicing. Although it is often stated that 5 percent of the doctors result in a majority of all claims, this number is misleading because high-risk specialties attract a disproportionately high number of claims.[10] The current system makes it hard to hold bad doctors accountable—they hire a lawyer, threaten to drag the hospital or licensing board through years of litigation. A typical result is a settlement that allows the doctor to continue practicing.

The Sources of Distrust of Justice. Distrust drives down the quality of care and drives up costs, but why is there so much distrust? Studies over the years on the effectiveness of justice tend to vary in their results, but they tend to show that, if the case goes to a jury trial, most juries come to a reasonable result. A recent study led by Professor Studdert found that almost two out of five medical malpractice claims were baseless, and that one out of four of these baseless claims resulted in payments.[11] On the one hand, this indicates that the system is reasonably effective in sorting the good from the bad. On the other hand, from the standpoint of a doctor, one out of four resembles Russian Roulette. People aren't willing to take the risk. In the case of tragic circumstances, moreover, studies indicate that juries are more prone to error, as with babies born with cerebral palsy.[12]

Distrust of justice is driven not just by the chance of error, but by the years-long process—an average of 5 years to get to *settlement,* in Professor Studdert's study. Even where the doctor ultimately prevails, a lawsuit is a horrible life-changing experience. For years the doctor goes to bed each night trying to figure out how to justify some choice made. I commend to the committee the recent essay in *The New Yorker*, "The Malpractice Mess," by Dr Atul Gawande.

Nor does the system work well from the standpoint of the injured patient. First, as Professor Sage has observed, it is hard to get a lawyer unless the claim is worth at least several hundred thousand dollars.[13] Next, the litigation drags on for years for injured patients as well as for doctors. It is probably accurate to suggest that the system favors whoever is in the wrong—they gain an advantage merely by threatening to drag the other side through interminable proceedings. Most shocking is the cost—the injured plaintiff typically pays 33 to 40 percent of any award or settlement to lawyers.[14] Over half the total cost of the malpractice system—$15–17 billion out of $28 billion—goes to lawyers and administrative costs.[15]

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[9] U.S. Department of Labor: Bureau of Labor Statistics, May 2005 National Occupational Employment and Wage Estimates for the United States, available at: *http://www.bls.gov/oes/current/oes*__nat.htm.

[10] U.S. Department of Health and Human Services, National Practitioner Data Bank, 2004 Annual Report (for September 1, 1990 to December 31, 2004), available at: *http://www.npdb-hipdb.com/pubs/stats/2004*__NPDB__Annual__Report.pdf.

[11] Studdert, David M., et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine*, vol. 354; May 2006, p. 2031.

[12] MacLennan, A., Nelson, K.B., Hankins, G., Speer, M., "Who Will Deliver Our Grandchildren?: Implications of Cerebral Palsy Litigation," *Journal of the American Medical Association*, vol. 294; 2005, p. 1688–1690.

[13] Sage, William, online discussion at PointofLaw.com, "Why Flatter The Trial Lawyers?," Dec. 6, 2005, available at: *http://www.pointoflaw.com/feature/condition*__critical1205.php

[14] U.S. Dept. of Health and Human Services, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System,", July 24, 2002, p. 10, available at: *http://aspe.hhs.gov/daltcp/reports/litrefm.pdf.*

[15] In a recent study, Harvard School of Public Health researchers found that the cost of litigating claims in the study sample consumed 54 percent of plaintiffs' awards. Studdert, David M. et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," New

Overall, while justice today eventually gets to the right result about three quarters of the time, this would not be considered a tolerable risk in other comparable professional activities (certainly not in healthcare). The combination of the risk of error, the harrowing process and growing costs has resulted in nearly universal distrust of American justice. This distrust, in turn, acts as a kind of acid corroding American healthcare. Quality, cost, professionalism, patient empathy, accountability and effective compensation for injured patients are all adversely affected by the defensive culture.

Special Health Courts. What's required, I believe, is a system of justice that aspires to reliability. Doctors need to believe that a dispute will be resolved based on accepted standards of effective healthcare. Patients need a system that can not only distinguish right from wrong, but will do so without an agonizing 5-year process. Most importantly, the system of justice must provide a foundation for a healthcare culture that is open, aspires to continual improvement and does not encourage (or permit) providers to squander billions in unnecessary tests.

Achieving these goals, we believe, requires creation of special administrative health courts. Our country has a long tradition of specialty courts in areas that are complex. In 1789, there were Admiralty Courts. We have Bankruptcy Courts, Tax Courts, and numerous administrative compensation systems including the Workers Compensation System and the Vaccine Injury Compensation Program. None of these areas are as complex as modern healthcare, and none is more important to our society.

Creating new courts is an ambitious undertaking, and we believe it is prudent to test the assumptions in pilot projects. While the pilots could take many forms, we believe they should incorporate the following features:

(1) Administrative law judges who handle only medical malpractice disputes, with written opinions on standards of care.

(2) Neutral experts, drawn from approved lists, would advise the court.

(3) Noneconomic damages paid according to a schedule depending on the injury. This achieves horizontal equity among injuries of the same kind, and also eliminates the incentive to keep litigating in the hopes (or threats) of a windfall award.

(4) A liberalized standard of recovery based on whether the injury should have been avoidable. Someone who comes into the hospital with pneumonia and comes out with a staph infection should be able to recover without having to prove how it happened.

(5) A requirement of transparency and preliminary procedures designed to resolve claims with a minimum of time and legal cost. Lawyers fees should be based on the time and investment they commit to the case, not a flat percentage of recovery.

(6). Connection to a regulatory department focused on patient safety and disseminating lessons learned.

The potential advantages of this system are enormous. A court that writes opinions based on accepted medical standards not only holds the promise of overcoming the debilitating distrust, but can provide affirmative guidelines for improving care. The regulatory body can collect and disseminate information to improve care. The incentives for defensive medicine will be sharply reduced. Moreover, affirmative cost containment is only possible when there is a court that will reliably defend the costs contained. Finally, patients will receive settlements much sooner, paying only a fraction of what they now pay in legal fees.

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 healthcare. Congress has broad powers to authorize pilots for specialized health tribunals under the Spending Clause, see *South Dakota* v. *Dole*, 483 U.S. 203 (1987); and under the Commerce Clause because medical injury litigation is economic activity that is in and affects interstate commerce. See *Gonzales* v. *Raich*, 125 S.Ct. 2195 (2005); *United States* v. *Lopez*, 514 U.S. 549 (1995). Contrary provisions of State law, if any, would be pre-empted under the Supremacy Clause. See *Silkwood* v. *Kerr-McGee Corp.*, 464 U.S. 238 (1984); *Pennsylvania* v. *Nelson*, 350 U.S. 497 (1956). Moreover, similar Federal administrative compensation systems have been upheld against constitutional challenge. *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).

Law is essential to a free society because it provides guidelines for reasonable conduct. Contracts will be enforced by their terms, and people injured by negligence

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England Journal of Medicine, vol. 354; May 2006, p. 2031. Tillinghurst-Towers Perrin has estimated that only 22 cents of a dollar moving through the U.S. tort system compensates a plaintiff for economic loss. 54 percent of that dollar never even reaches the victim (21 percent goes to administrative costs; 19 percent goes to the plaintiff's attorney fees; and 14 percent goes to defense costs.) Tillinghast-Towers Perrin, "U.S. Tort Costs, 2003 Update," December 2003, p. 17.

will be compensated for their injuries. But law undermines freedom when it fails to offer predictable guidelines, and when it tolerates claims against reasonable conduct. Because law today offers no guidelines or predictability in healthcare disputes, physicians, nurses and other dedicated healthcare professionals no longer feel free to act on their best judgment. This in turn has tragic effects on the quality and affordability of healthcare in our country. By restoring reliability to healthcare disputes, special health courts hold the promise of bringing order and good sense to the vital decisions needed for effective, safe and affordable healthcare in America. Thank you.

The CHAIRMAN. Mr. Boothman.

Mr. BOOTHMAN. Thank you, Chairman Enzi, and thank you to the committee members, especially Senator Clinton, with whom I've worked already on her proposed bill. My name is Rick Boothman, and I am the chief risk officer for the University of Michigan. We have gotten some notoriety over the years, and I guess it's safe to say I bring you the view from the trenches, not from the ivory towers.

I am not a scholar. I was a trial lawyer and represented doctors and hospitals in Ohio and Michigan for 22 years before coming to the university in 2001, mainly because I believed we could handle our claims better.

I will depart from the witnesses you have heard already in one way and probably with my own constituency: I don't believe that the system needs radical change. I do believe it needs some fixing. But I think our experience has proven that we can reduce medical malpractice risk without major revisions and abandonment of a system that has developed over hundreds of years just by adhering to some principal ethics and by making one observation that is a little bit sidetracked from the direction of this committee, and that is this; and I say this out of the deepest respect and love for the profession that I've served for over a quarter of a century. I think the malpractice problem is stubborn in part because the medical profession has concentrated so hard on lawyers and the legal system that it has not paid attention to its own complicity in this problem.

Patients in every study that I'm aware of that's looked at why patients sue their doctors really want three things: accountability, answers, and assurance that the mistake won't happen again. And built on that realization, we've created a claims system which has caused our claims to drop from almost three-quarters of our claims in less than 4 years; we're down to three-quarters. Our costs are less than half what they were before. Our reserves, the cost, the actuarial estimate of our claims portfolio went from $70 million in 2001 to less than $20 million.

And nothing's changed in Michigan. Tort reform happened in Michigan in 1994, not lately, and our claims have only changed since 2001. Our disposition time, from notice of a patient injury to disposition of that, has gone from 20.7 months to 9.5 months, and it's all been based on simple changes that I think mostly arise out of ethics and common sense.

The first thing we did was pass three simple principles and get agreement on these. First, as a system, we committed to compensating people who were injured by unreasonable medical care at the University of Michigan. Second, we committed to defending ourselves aggressively when the care was reasonable regardless of

the medical outcome, because doctors and nurses operate in an inherently dangerous environment, where even the most reasonable decision can still result in catastrophic illness. It cannot be just about the outcome. And third, we committed to learning from our patients' experiences whether there was a medical mistake or not.

Having made those commitments, we have designed a system that is relatively fearless in the medical community. We have committed to moving forward, because essentially what we have said is we will not say anything differently in court than we're saying to ourselves. If we've concluded that our care was unreasonable, then, what's the harm in talking to the patient?

So the key is getting to that conclusion first and then having the guts, if you will, to step forward and talk to the patient. Our staff is encouraged to, in an unvarnished way, talk with honesty and credibility to patients at the point of complication. We, in our claims mechanism, talk to our patients, whether they are represented or not, openly and honestly at the point of claim.

If the claim is defensible, we explain to them why we think it is, because the interesting realization is at that moment in time, before a lawsuit has been filed, the patient and the patient's lawyer have exactly the same interests we do: nobody wants to make a mistake. If they have a belief that a medical mistake has happened, and we think that's not true, why not sit down and talk about it?

So we have discussions, and I have included in my written materials a copy of the flow of our claims management program. But we open the table to discussions openly and honestly regardless, confident in our conclusions about whether the medical care was appropriate or not, and that has resulted in a dramatic decrease in all of our claims.

There are some points I want to make, and I understand my time is brief. Changes to the system I don't think have to be wholesale, but I do think there need to be changes. We need to deal with scientific uncertainty, junk science, and testimony from outright charlatans. Medical careers and millions of dollars are at stake, and too often, it becomes a beauty pageant of experts, not hard science, and judges need to do their job in dealing with that. When we select juries, we disqualify those with any knowledge of the subject matter and then expect them to recognize who's lying and who isn't when the experts take the stand. There has to be some mechanism for ferreting out what we know scientifically and what we don't.

All parties benefit from a healthy insurance industry. Caps on noneconomic recovery, whether personally I find them abhorrent or not, allow for some predictability in the business, and even patients benefit from a healthy insurance industry. I think we have to consider that.

Catastrophic injury insurance plans are possible. I've worked with some insurance folks, and I don't understand why States don't pull together a catastrophic injury insurance plan that would serve as an umbrella plan. Even low-risk specialties like dermatologists, at the right price, would love to have that kind of coverage, and it's possible. Punitive damages, on the other hand, have absolutely no place in this discussion. They feed the hysteria and are overkill.

Speaking from experience, patients crave honesty and transparency. The problem is that it is a heck of a lot easier to be honest and transparent if you are not worried about financial ruin. We have to find a way to allow that discussion to occur without penalizing our caregivers unnecessarily.

Litigation was never meant to be the first resort to resolve disputes between people. Unfortunately, it has become that. I think our system works because we have caused it to be the last resort. We say to our patients and to our staff both, we will do everything we can to avoid litigation without sacrificing our principles but reach an agreement and then use litigation to handle intransigent disagreements.

I think alternatives loosely characterized as no-fault systems will not work. To know the difference between reasonable and unreasonable care, to understand whether a patient's outcome has changed because of the medical care still is going to require the kind of litigation we see anyway. Deny and defend is the enemy of transparency. Doctors need to understand how their own behavior feeds this problem, and by opening up and talking to patients, I think we can intercept a lot of people who end up going to lawyers in the first place.

The medical community has got to ask themselves a different question, and that is: Why do my patients feel the need to see a lawyer in the first place? And I think that there are ways, and we are exploring those all the time at the University of Michigan and intercepting those things.

Last, focusing on patient safety and patient communication rather than whether to discard our litigation system I think is the key here. And getting, and moving that discussion to how can we be safer is really all the answer here. How can we be safer, and how can we improve patient communication?

The medical community sets itself up for failure all too often by establishing unreasonable expectations in its patients and not talking about problems that happen afterwards.

Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Boothman follows:]

PREPARED STATEMENT OF RICHARD C. BOOTHMAN

SUMMARY

In 2001, the University of Michigan Health System changed the way it responded to patient injuries, complaints and claims. Its approach was predicated on three simple, inarguable principles:

1. We will compensate quickly and fairly when inappropriate medical care causes injury.
2. We will defend medically appropriate care vigorously.
3. We will reduce patient injuries (and therefore claims) by learning from mistakes.

Adherence to these principles fostered transparency and honesty in the health system's approach to patients and their attorneys which has, in turn, caused a steady drop in malpractice claims and expense. In the process, what started as an effort to reduce claims cost has evolved dramatically into more substantive initiatives to improve patient safety and communication.

The University of Michigan's experience yields lessons for wider discussion of tort reform:

A. Medical care cannot be judged simply on outcome. The system must do a better job of making the distinction between reasonable and unreasonable care.

B. Scientific uncertainty, junk science and testimony from outright charlatans must be filtered out.

C. All parties benefit from a healthy insurance industry.

a. *Caps on noneconomic recovery.* Caps on noneconomic recovery (elements of damage not subject to calculation) are one way to blunt the wide swings.

b. *Catastrophic injury insurance plans.* Are possible and should be explored.

c. *Punitive Damages.* There is simply no place for punitive damages.

D. Honesty and transparency are easier to achieve if caregivers do not believe they are risking their financial lives by talking to their patients.

E. Litigation was never meant to be the first resort for resolving disputes. Reform must offer the opportunity, incentive or if necessary, impose a requirement that the parties talk to each other before resorting to litigation as a means for resolving disputes.

F. Alternatives loosely characterized as "no fault" systems will not work.

G. "Deny and defend" is the enemy of transparency. Mainstream medicine must turn its attention to its own complicity in this problem and stop blaming trial lawyers or the system for the crisis.

H. Gaps in the social safety net drive some litigation.

I. Focusing on patient safety and patient communication rather than whether or not to discard our legal system is absolutely essential.

J. As long as this issue is treated as a battle to be won or lost, it will not be fixed. I applaud the work of this committee and specifically, the efforts of Senators Enzi, Baucus, Clinton and Obama in this regard.

INTRODUCTION

I want to thank you, Chairman Enzi, Ranking Member Senator Kennedy and members of this committee, especially Senator Clinton, for the opportunity to appear today. I am the Chief Risk Officer for the University of Michigan and in that capacity, I have responsibility for overseeing the manner in which the University of Michigan responds to patient injuries, patient complaints and patient claims.

I came to the University in July 2001 as Assistant General Counsel after 22 years of trial work, defending doctors, hospitals and other healthcare providers in Michigan and Ohio. In private practice, I represented a wide variety of care givers, from individual physicians to large group practices, from small inner city, minority-owned hospitals to a chain of osteopathic community hospitals to large academic medical centers like the University of Michigan and the Cleveland Clinic Foundation. I left trial practice and the law firm I founded because I believed the University could improve the way it handled patients' complaints, claims and litigation.

In 22 years of practice, not a single client ever asked me what they could learn from the cases I handled for them. Driven by that realization, I was convinced that the University could not only save money in the short run through smarter claims management, but reduce future patient claims by learning from our patients' complaints. I could not have imagined that our experience would garner the national and even international attention it has, and I certainly never envisioned our work would lead to an opportunity to appear before a committee of the U.S. Senate. Thank you.

I am not a scholar. I have not had much time to research and read what has been written on the issues this committee has undertaken to study. My opinions arise from my experiences representing doctors and hospitals in malpractice cases, my experiences with the University of Michigan's program and frankly, from common sense. I am not an advocate for a particular interest group or point of view—indeed, some of my views elicit vigorous disagreement from UM doctors. I am well aware that my opinions do not sit entirely well with either end in this discussion and there are those in the medical and insurance communities who view some of my opinions as treasonous. My trial lawyer's instincts strongly suggest that if my views please neither side entirely, we very well may be on the right track.

What started as a focused effort to reduce claims costs at the UM has evolved to reveal the roles that inadequate commitment to patient safety and unmindful patient communication play in the stubborn problem which has plagued the medical community for decades. I appear today, not to "win" a fight, but to help fix this problem.

IDENTIFICATION OF THE PROBLEM

This committee's interest is identification of new ideas to make the system, (presumably the litigation system) work better for patients and physicians. I suggest that clarification of the problem is a necessary first step. I am convinced that the problem stubbornly persists despite past attempts to address it in large part because the treatment to date has targeted the wrong diagnosis.

Few involved in the medical malpractice arena would argue with Professor Sage's assessment in his March 2005 DePaul Law Review Journal article:

> "For over a century, American physicians have regarded malpractice suits as unjustified affronts to medical professionalism, and have directed their ire at plaintiffs' lawyers . . . and the legal system in which they operate."[1]

We ask a lot of our doctors, nurses and other healthcare providers. They are by nature, an unbelievably committed group, driven mostly by a strong sense of personal reward derived from helping sick people. Yet, they spend every working day in an inherently dangerous environment, a world in which the simplest decision, like prescribing antibiotics for a child's first ear infection, can have devastating consequences. We clearly need to better understand the trauma to the caregiver when such a catastrophe occurs, but it should come as no surprise that physicians reflexively blame the messenger when a patient asserts a claim.

Understandable human emotions may feed the "deny and defend" response to patient's complaints, but few believe the strategy has been effective. More importantly, that strategy has exacted a heavy cost. Simplistically blaming the legal system and plaintiffs' lawyers for patient complaints has stunted earnest efforts to improve patient safety and skirted recognition that many complaints could have been avoided by more thoughtful patient communication. Improving patient safety and patient communication honestly and openly is treatment more likely to cure the malpractice crisis than defensiveness and denial.

The University of Michigan's approach is effective in my opinion, because we have focused our efforts more accurately on the primary causes for most patient litigation: a failure to be accountable when warranted and a reluctance to communicate. Isolating the factors that comprise our approach can inform a broader debate on "making the system work better for patients and doctors."

BACKGROUND

The State of Michigan's last tort reforms took effect in April 1994. (See attached) Among other provisions, those statutes,

- Created a compulsory 6-month pre-suit notice requirement;
- Created a two-tiered cap on noneconomic recovery, a lower general cap and an upper cap applicable to central nervous system injuries and injuries to reproductive organs rendering the patient incapable of procreation;
- Tightened qualifications necessary for experts testifying;
- Required an affidavit of merit by qualified experts to support any Complaint and Answer to Complaint filed.

The reforms had little effect on the UM's claims experience and almost no impact on the way in which the University responded to claims. Our claims rose, modestly but steadily from 1994 to 2001 and our costs rose with them. Pro activity was a fairly foreign concept and I was aware of no hospital or insurance company in southeastern Michigan that systematically utilized the pre-suit notice period to resolve claims or even, for that matter, prepare for litigation. The University, for the most part, still responded in the traditional "deny and defend" mode. Coupled with a distinct aversion to the risk of trial, the combined strategy, typical for mainstream medicine even today, virtually guaranteed that resolution of patients' disputes would take a long time and would cost a lot, financially and otherwise. Like all of my other clients at the time, the University had no systematic way to learn from its claims.

In August 2001, the UMHS had 262 open claims, varying from pre-suit notices to active litigation. Actuaries valued the portfolio for reserves at more than $70 million. For an institution of our size and complexity, ours was actually an enviable record. Though no public disclosures exist to my knowledge, other institutions of similar size in our area reportedly had two and three times as many claims.

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[1] Sage, William, Medical Malpractice Insurance and the Emperor's Clothes 54 DePaul Law Review 463, 464 (24 March 2005).

UNIVERSITY OF MICHIGAN CLAIMS EXPERIENCE SINCE 2001

Claims numbers fluctuate as existing cases are settled or dropped and new cases arrive. But using the month of August as a benchmark, the UMHS's claims numbers have dropped steadily despite a considerable increase in clinical activity over the same period.

- In August 2001, we had 262 total claims;
- In August 2002, we had 220;
- In August 2003, we had 193;
- In August 2004, we had 155;
- In August 2005, we had 114;
- Since August 2005, we have dropped below a hundred.

Our average claims processing time dropped from 20.3 months to 9.5. Total reserves on medical malpractice claims dropped by more than two thirds. Average litigation costs have been more than halved.

Our approach may have achieved the unthinkable: it pleases doctors *and* trial lawyers. Surveys conducted in early 2006 of our medical faculty and the plaintiff's bar in southeastern Michigan yielded approval from both sides. In our physician survey, more than 400 UMHS faculty physicians responded, and:

- 87 percent said that the threat of litigation adversely impacted the satisfaction they derived from the practice of medicine;
- 98 percent perceived a difference in the University of Michigan's approach to malpractice claims after 2001;
- 98 percent fully approved of the approach;
- 55 percent said that the approach was a "significant factor" in their decision to stay at the University of Michigan;
- The only consistent criticism was that they wanted more attention from Risk Management to assist them in reducing the threat of malpractice.

At the same time, we surveyed members of the plaintiff's bar in southeastern Michigan, all specializing in medical malpractice:

- 100 percent rated the University of Michigan "the best" and "among the best" health systems for transparency;
- 90 percent recognized a change in the University of Michigan Health Systems approach since 2001;
- 81 percent said that they had changed their approach to our Health System in response;
- 81 percent said their costs were lower;
- 71 percent admitted that when they settled cases with the University of Michigan, the settlement amount was less than anticipated;
- 86 percent agreed that the University of Michigan's transparency allowed them to make better decisions about the claims they chose to pursue; and
- 57 percent admitted that they declined to pursue cases after 2001 they believe they would have pursued before the changes were employed.

UNIVERSITY OF MICHIGAN HEALTH SYSTEM CHANGES BETWEEN 2001 AND 2005

A Principled Approach

Initially, a simple set of principles, (in my opinion, inarguable), were constructed and we began to make claims decisions immediately in the context of that framework:

1. We will compensate quickly and fairly when inappropriate medical care causes injury.
2. We will defend medically appropriate care vigorously.
3. We will reduce patient injuries (and therefore claims) by learning from mistakes.

These principles were publicized to our staff, our trial attorneys, the courts and directly and personally to plaintiff's lawyers in southeastern Michigan. Adherence to these principles created consistency in our response to claims and began to build confidence among our staff.

Distinguishing Reasonable From Unreasonable Medical Care

Commitment to these principles was, and remains essential to every other aspect of our approach. Key to honoring these principles is understanding the difference between reasonable and unreasonable care and an infrastructure and system for hard claims analysis was constructed to utilize whatever pre-suit period we would have to arrive at the pivotal determination.

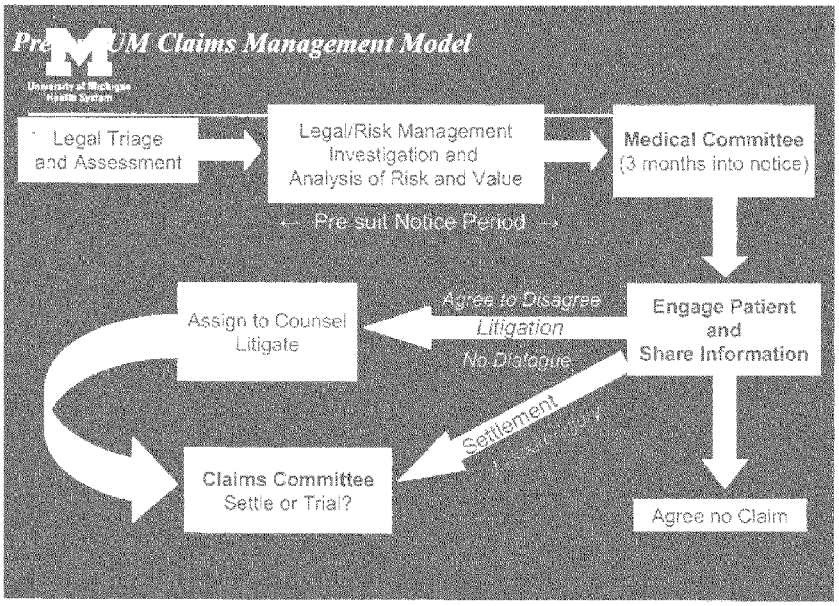
The Benefits of Transparency

Flowing directly from this commitment is transparency. Decades of lawyers' admonitions not to talk about claims until the cases were resolved disappeared when we committed to acting in accordance with our conclusions about the reasonableness of our care. Concerns for compromising litigation virtually disappeared—if we concluded that our care was unreasonable and harmed a patient, we would be moving to resolve the claim. If we concluded that our care was reasonable, did it really matter if those conversations were revealed through discovery?

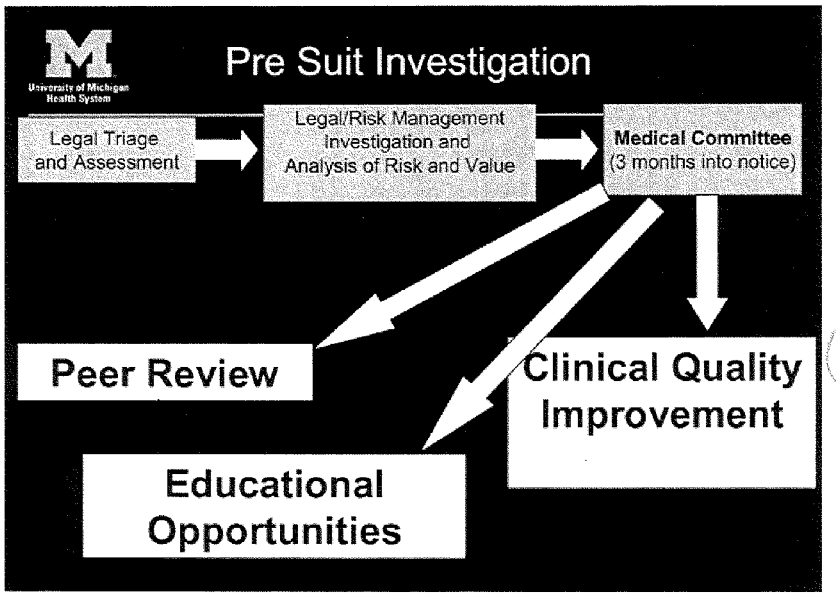
It became immediately apparent that our interests and the patient's interests at that point were exactly the same: as both faced the prospect of litigation, neither side wanted to make a mistake. We did not want to defend a claim for years only to decide the claim warranted settlement and the patient and his lawyer obviously do not want to engage in expensive, time consuming and emotionally draining litigation only to lose the case. Discovery eventually leads to full disclosure anyway; so why not simply share our conclusions early and inexpensively? If our conclusions prove to be wrong, we want to know that before litigating. We discovered that nearly every plaintiff's lawyer came to the same conclusion.

Our process then lead to open dialogue with our patient and if represented, the patient's lawyer. Open, honest, and robust, discussions occur between patients and their doctors, doctors and the lawyers threatening to sue them. Expert opinions are exchanged and agreements are reached: sometimes agreements to drop the claim, sometimes to settle, sometimes to apologize and occasionally, to disagree. Constructive engagement allows the parties to mutually understand what they are facing with litigation and both sides can move forward with "informed consent." In the dynamic created, the decision to litigate becomes a mutual one and litigation is relegated more and more frequently to the role it was meant to play: a last resort for resolving intransigent disputes.

Claims at the UM follow this flow:



Commitment to these principles opens the door to immediate and decisive quality improvement measures and peer review opportunities. We are routing our patient's complaints, even those deemed without substance, through a process that asks in every single instance: Could we have done better? What improvements could be undertaken to avoid these kinds of complaints in the future? Why did this patient complain and how can we avoid the same thing happening again? Are there lessons to be learned? And we are not waiting until the claim is resolved.



Commitment to these principles stimulates a more robust communication between our doctors and patients at the point of care and complication. Our staff, essentially "finally granted permission by the lawyers" as one of our doctors characterized it, to speak openly is also principle-based and I believe this openness, intelligently and sensitively accomplished, will prove to be effective at intercepting patients before they feel the need to see a lawyer.

Despite widespread convictions that patients see lawyers because they are looking for a financial windfall, studies done to understand why some patients hire lawyers all yield the same results: patients are actually seeking accountability, answers and assurances that the same complication will not befall anyone else. My own experience cross-examining probably thousands of witnesses and litigants confirms the studies' findings. Rather than demonizing lawyers and the legal system, physicians need to ask a more difficult question: "Why would my patient feel the need for an advocate?"

None of these changes could have been implemented or accomplished without strong and committed leadership and robust participation by our physicians, nurses and other healthcare providers. Openly acknowledging that patient safety is at the heart of many patient complaints, our Chief of Staff, Skip Campbell, M.D. has undertaken bold initiatives in systemwide peer review and patient safety improvement with the avowed goal of becoming the "safest hospital in the *United States*".[2] The UMHS's chief executive officer, Doug Strong, recently observed at a board meeting that though we may be realizing significant savings through more prudent claims management, real savings lies in improving patient safety and that would be a driving force in the future.

What began as a set of strategies to save costs of litigation has evolved dramatically in a different direction: by focusing on patient safety and improved communication, we are now confident that medical malpractice will be relegated to background noise.

LESSONS FROM THE UM EXPERIENCE

A. Healthcare professionals work in an inherently and unpredictably dangerous environment in which the simplest decision can have catastrophic consequences for their patients. Medical care cannot be judged simply on outcome. The system must do a better job of ensuring that the distinction between reasonable and unreason-

[2] Anstett, Patricia, *U-M Hospital's Goal: Safest in the Nation.* The Detroit Free Press, February 24, 2004.

able care is made with clarity and based on sound medical and scientific knowledge. All too often, these conclusions turn on an expert's "performance" in the courtroom and not on scientific and medical substance. The failure of our system to ensure this is a major contributor to physicians' belief that the system does not provide justice for them.

B. Scientific uncertainty, junk science and testimony from outright charlatans must be filtered out. This may mean a role for "medical courts," but there exist in probably every jurisdiction in the country tools for courts to ensure claims are not based on shaky scientific and medical grounds. Evidentiary hearings, court-appointed masters, bifurcation of trials are all currently available to trial courts and though employed in other fields like real property litigation, are almost never used in medical malpractice suits. (Interestingly, the medical specialties have also failed to address this problem, though there are budding efforts underway to censure specialty board members that render clearly dishonest and unsupported testimony in Neurosurgery and Ob/Gyn.) At a minimum, judges must accept their role as gatekeeper of the evidence and robustly screen complicated expert opinions before allowing them to go the jury.

C. An inconsistency continues to plague trial practice in this specialty: historically, opinion testimony deemed an infringement on the province of the jury and witnesses were restricted to factual testimony. As issues became increasingly complex, rules of evidence relaxed and expert opinion testimony was allowed where the court deemed the issues outside the experience of the average juror. We select juries by disqualifying those with knowledge of the subject matter, then expect these people to recognize which expert is lying and which one is accurate. With physicians' careers and millions at stake, the "battle of the experts" all too often becomes a beauty pageant.

D. We submit these complicated issues to the very people the court has acknowledged cannot understand them and still expect doctors to feel that they are being judged by a jury of their peers.

E. All parties to the issue are benefited by a healthy insurance industry. No patient's lawyer wants to find out that the doctor involved is un- or under-insured. Hospitals for years have served as excess carrier to physicians with too little insurance protection. Like it or not, the insurance industry requires some measure of loss predictability in order to remain financially healthy and in order to attract companies to offer this coverage. There are measures which can be taken to assist in this regard:

a. *Caps on noneconomic recovery.* Caps on noneconomic recovery (elements of damage not subject to calculation) are one way to blunt the wide swings. They are by definition arbitrary and will pose a hardship on some injured patients, but may be a necessary evil. Though remedies to runaway verdicts like remititur and new trials also are available to trial courts, those remedies are rarely used, are not reliable nor predictable.

b. *Catastrophic injury insurance plans.* There is no reason States could not pull together catastrophic injury insurance plans which would provide catastrophic injury protection over a base primary insurance policy. The physicians could subscribe for very attractive premium costs, the lower risk physicians would subsidize the higher risk specialists if constructed properly. Participation would be conditioned on the physician's agreement to peer review, quality audits and other requirements.

c. *Punitive Damages.* In my opinion, there is simply no place for punitive damages. Invariably, the anomalous case reports arise in States with punitive damages. The existence of this form of recovery invites lawyers to speculate on high value—low liability cases. Adequate measures exist to punish physicians who deserve punishment.

F. Honesty and transparency are much easier to achieve if caregivers do not believe they are risking their financial lives or their insurance coverage by talking to their patients. Catastrophic injury protection is one way to address this problem.

G. Litigation was never meant to be the first resort for resolving disputes. Reform must offer the opportunity, incentive or if necessary, impose a requirement that the parties talk to each other before resorting to litigation as a means for resolving disputes. The Michigan scheme offered the opportunity and it is now increasingly used, but for the first 10 years few insurance carriers or hospital systems availed themselves of that opportunity. Perhaps more than any other feature to the UM's approach, we have found that the free and credible exchange of information is responsible for the UM's success. All parties deserve to know that every opportunity to resolve the misunderstanding, dispute, or claim has been made before litigation is invoked.

H. Alternatives loosely characterized as "no fault" systems will not work. The medical and insurance communities will not be fairly served by creating an entitlement not based on the reasonableness of care. Physicians championing these alternatives and anxious to eliminate confrontation will not feel that justice has been served if a check is written on their account every time a patient's outcome is less-than-optimal. And the theoretical underpinning of these proposals is inherently flawed: whether you seek to determine if the outcome resulted from negligence, or preventable, or avoidable error, the net effect from a litigation perspective is the same. All require expert testimony, discovery and the rest and the legal costs allegedly saved by these proposals are lost in the determination.

I. "Deny and defend" is the enemy of transparency. Mainstream medicine must turn its attention to its own complicity in this problem and stop blaming trial lawyers or the system for the crisis. All of the evidence suggests that changes in our approach to patients may alleviate this problem, yet as long as Medicine is in denial, those changes will not occur. Hospitals and doctors must confront the ways their own behavior actually drives patients to feel the need for an advocate to deal with them. This problem cannot be fixed without active participation and leadership from physicians.

J. Gaps in the social safety net drive some litigation. Families faced with the results of catastrophic outcomes sometimes are driven to consider litigation as a means of financial survival. This driver needs to be addressed.

K. Focusing on patient safety and patient communication rather than whether or not to discard our legal system is absolutely essential. The best way to deal with the medical malpractice crisis is to turn our attention in those directions which requires bold and focused leadership from physicians and nurses.

L. As long as this issue is treated as a battle to be won or lost, it will not be fixed. The polemics must be set aside in recognition of the fact that we are all in this together, that persistence of this problem continues to cost every American money and more. Radical proposals like scrapping our tort system must give way to detailed, focused efforts designed to reach the real problems. I applaud the work of this committee and specifically, the efforts of Senators Enzi, Baucus, Clinton and Obama in this regard.

[Editor's note—Due to the high cost of printing, previously published materials submitted by the witness (i.e., Appendix-Michigan Malpractice Laws) may be found in the files of the committee.]

The CHAIRMAN. Ms. Sheridan.

Ms. SHERIDAN. Good morning; thank you.

First, I'd like to begin by thanking Senators Enzi and Baucus for their courage to jointly propose bold, new territory and to challenge the longstanding stalemate on tort reform. I also thank you for valuing the contribution of real life experiences in the tort system.

I think I was further down in the trenches than Richard here. My family has experienced two medical errors with devastating impact, one that resulted in the death of my husband, Patrick, due to the failure to communicate a malignant spinal cancer which resulted in a delay in treatment for 6 months. The tumor penetrated Pat's spinal cord, severed it, paralyzed him, and he died in 2002.

The other error resulted in the permanent brain damage of our newborn son Cal in 1995 from the failure to test and treat newborn jaundice. This condition is known as kernicterus, and today, Cal has cerebral palsy. He is hearing impaired, speech impaired, and he has uncontrollable movements of his legs and arms.

My family has learned from experience that the legal system does not serve the needs of families who have been harmed, and I say that even though in the end, many would say we won our medical malpractice cases. Cal's litigation took 8 years. Pat's case took 4 years. We were left on our own to take care of Pat and Cal with our own resources. I maxed out two credit cards and our home equity line to take care of both of them during that time.

During those 8 years, we were in a 7-week trial that we lost. We were in a State U.S. Supreme Court hearing, three mediations,

hundreds of depositions, hundreds of thousands of dollars, and finally settlements that amounted to a fraction of the total amount spent by all.

Unfortunately, in media and tort conversations, patients are always characterized as greedy and eager to sue when medical error occurs. We sued in Cal's case because we had to. Cal's life care plan is several million dollars, and as parents, we had the responsibility to provide the best care for our son. In Pat's case, we made it very clear to the hospital and doctor that we did not want to sue, because we found the system dishonorable. Initially, we had sincere conversations; however, after the insurance companies and the legal counsel became involved the communication came to a screeching halt.

After being told not to contact them anymore, we filed a lawsuit on the last day of the statute of limitations and entered into a 4-year litigation process. During that time, my husband Pat died, never knowing if his son's case would ever result in justice or if Cal would be financially taken care of. He also died feeling betrayed by a doctor who was once his hero, who disappeared instead of sitting down and talking with us.

Now, as a widow and a mom to a disabled little boy and an 8-year-old little girl, I have gained a unique insight into the reality of our current tort system. What I have learned from my position as chair of Patients for Patient Safety at the World Health Organization and President of Consumers Advancing Patient Safety, where we work for patients from all over the world, is that medical error is an incredibly human phenomenon regardless of geographical phenomenon, economic condition, or language, but sadly is treated in a tragically in-human manner.

In my late husband's words, we witnessed the intolerable absence of integrity and honor in medical malpractice. Indeed, the errors caused tremendous sadness, and loss of life that I never would have imagined as a woman or mother. But the errors were undoubtedly unintentional and truly mistakes, and Pat and I knew that. But what happened after the medical errors and how my family was treated through the litigation process, a process that we did not want to enter and tried in every manner to avoid, was very calculated, deliberate, and by far the most disturbing experience in my life.

But Pat and I trusted the wisdom of the jury, the integrity of professionals, and the long history of our judicial system. But what we witnessed was a system in deterioration, a system that we naively believed would be based on the truth, fair compensation, and what was right. We learned, with great disappointment and even alarm, that litigation is a win-at-all-costs blame game that is wildly inconsistent, is deviously strategic, and rarely makes our healthcare system safer.

Today, kernicterus and lost pathologies happen over and over and over again. Our lawsuits had nothing to do with creating a safer healthcare system, unfortunately. We learned that the system where patients who file lawsuits are vilified, abandoned, and sometimes even denied healthcare. In Cal's case, there is one pediatric neurologist in the State of Idaho, and he sent us a registered letter

stating that he will not treat my son, even in the event of an emergency.

The biggest lessons learned and opportunities of the future include, first, we witnessed a legal system infested with expert witnesses able to offer unscientific and fictional testimony known as junk science for handsome fees. Now, typically, you hear about this on the other side of the fence. This happens to plaintiffs as well. And there are no consequences to those expert witnesses. Our judge stated, in a memorandum declaring a mistrial when we lost our first trial for our son that the expert witness testimony was offered for the mere purpose of obscuring the actual circumstances and misleading the jury. This is wrong, and this needs to be investigated.

Second, I also witnessed a system that pressures patients to sign gag clauses so we can't speak openly about the case, which ultimately could help prevent future injuries. With regard to kernicterus, all but a few cases have been effectively buried by confidentiality agreements, a condition of settlement insisted upon by doctors and hospitals. They are just wrong, and they are very dangerous to the public health.

Gag clauses are nothing short of bribes and intimidation. I can only ask myself if Cal would have kernicterus now if he could walk, if he could speak clearly, if some of the cases before his injury had been made public before his birth. We must incentivize transparency. Finding a way to declare confidentiality agreements contrary to public interest is an excellent place to start.

Third, something very disturbing to me about the traditional tort system is the tremendous variation between awards for patients and families with similar needs. There has been a kernicterus verdict in this country of close to $90 million. Cal got a tiny fraction of that, and I know families who got a fraction of what Cal got. Their children will inevitably become a burden to the Medicaid system, and most, including my son, Cal, already are. Justice should be equitable.

It is my understanding that the tort system was created for powerful, honorable reasons, and that was for the people. So I ask all of you involved in tort reform to follow these guidelines. Do it for the right reason. Remember that people who experience medical error are not just dollar figures. We are your loved ones. We are you.

And closing, I invite you and I challenge you to envision a system that is fair and reliable and ask you to use your power, your courage, and your sense of justice to shape innovative programs that mark a return to integrity and honor. For those of you who believe the current tort system works, it does not. I have witnessed the dark side and the underbelly of the tort system. For those of you who believe that arbitrary caps on noneconomic damages are the answer, well, first of all, we know it hurts the most severely injured, and second of all, it is a cowardly solution that is unwilling to drill down to the real problems. But most importantly, let's truly serve the people who are relying on you, like dads and babies.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Ms. Sheridan follows:]

PREPARED STATEMENT OF SUSAN E. SHERIDAN, MIM, MBA

Good morning. I would like to begin by thanking Senators Enzi and Baucus for their courage and foresight in developing S. 1337, the "Fair and Reliable Medical Justice Act." It is my pleasure to be here today to share with you the experiences of my family with the medical litigation system, and those of other consumers who I have come to know.

My name is Susan Sheridan. I live in Boise, Idaho. I am a mother and a widow. I also am the President of a nonprofit organization called Consumers Advancing Patient Safety—or CAPS—which was established in 2003 by healthcare consumers and providers working together to create a healthcare system that is safe, compassionate and just. I also serve as the chair of a World Health Organization (WHO) initiative called Patients for Patient Safety, one of six programs launched in 2004 that together make up the WHO's World Alliance for Patient Safety. Our program recruits consumers from around the world to bring their wisdom and experience to health ministers and policymakers interested in the real interests of patients and families. In the past 6 months, we have convened workshops for proactive, partner-oriented consumers and healthcare leaders in the United States and the United Kingdom, with similar events planned in the next 6 months in Canada, Argentina, Africa and the Middle East.

Through my own experience and my interaction with others, I have become acutely aware of the importance of aligning the signals and incentives of the tort system with patient safety goals. We will not achieve safer, more compassionate healthcare if our legal systems continue to tolerate and encourage behaviors that hide lessons learned from medical error, that convert patients and their providers into enemies when they need to heal, and that reduce trials into jousting matches between exorbitantly paid medical experts. Tort reform, as it is usually understood, remedies none of these problems. For these reasons, we applaud the fresh, forward-looking, bipartisan approach represented by S. 1337.

My family has experienced two medical errors with devastating impact. My husband, Pat, died in 2002 due to the failure to communicate a malignant cancer of the spine. His pathology tests showed an aggressive cancer, but they seem to have been lost between the hospital and his surgeon's office for a few weeks, and then inserted in my husband's medical record without being reviewed. When the tumor recurred 6 months later, it had grown into his spinal cord and it was too late to save his life.

In 1995, our first child, Cal, suffered permanent brain damage during his first week of life from the failure to test and treat newborn jaundice. This condition, known as kernicterus, is highly preventable by exposure to a spectrum of light, a process known as phototherapy. Today Cal has cerebral palsy, is hearing and speech impaired and has uncontrollable movements of his body.

My family has learned from experience that the legal system does not serve the needs of families who have been harmed, and I say that even though in the end many would say we "won" our malpractice cases.

In Cal's case, we sued because we believed in the legal system . . . and because we had no other choice but to seek compensation. Cal's lifetime medical, rehabilitative and special needs costs are estimated to be in the millions of dollars. As parents we had the responsibility to care for our son who, despite extreme physical disabilities, is not cognitively impaired. In fact, Cal is a bright, creative boy with both great potential and an extraordinarily challenging future.

From the beginning, the hospital and doctor defendants pursued a two part strategy in Cal's case: vilify Pat and me by suggesting that we were trying to get rich off our son's injury and challenge Cal's diagnosis. Although we produced national experts who testified that Cal had classic kernicterus, the defense got past a summary judgment motion by producing an expert who said he was only 49 percent sure that Cal had kernicterus. Another stated that perhaps I had passed a virus to Cal through the placenta. After a 7-week trial, the jury found for the defense, a verdict that was subsequently set aside by the trial court judge based on his determination that the expert testimony offered was unsound. In his memorandum opinion, the judge wrote:

> The syntactical contortions which counsel and the witnesses wound through to deliver these opinions were wondrous to observe. One expert conceded that he was only 49 percent sure that the collection of symptoms established kernicterus, this therefore justified his opinion that more probably than not, Cal did not have kernicterus, although he could not identify through differential diagnosis any other condition or disease with the same constellation of symptoms which might exist.

He went on to observe,

> I have great difficulty when the expert appears to be straining an opinion to meet the requirement of advocacy. Unfortunately in my experience, this latter spectre occurs far too frequently in medical malpractice cases, where it appears to me that medical witnesses are willing to bend their testimony . . .
>
> All of the experts, on both sides, viewed this case as a competition—a verbal jousting match between lawyer and witnesses. The thrust and parry between witness and examiner was wondrous to behold . . .
>
> Although technically superb, the cross examination of these experts truly offered little opportunity for the jury to plumb the depths of the expert's opinion, and measure the technical differences between the views offered.

(*Sheridan* vs. *Jambura* et al, Memorandum Decision, District Court of the Fourth Judicial District of the State of Idaho, in and for the County of ADA, Case No. CV-PI 97-00266-D, July 19, 1999, attached as Exhibit 1.) The judge's order setting aside the jury verdict was appealed, ultimately to the Idaho U.S. Supreme Court, which affirmed and ordered a new trial. Discovery started again, but this time the hospital's defense strategy completely changed. They no longer challenged the diagnosis; the theory this time was that Cal had kernicterus, but it was completely his pediatrician's fault.

I know among lawyers it is considered normal to plead alternative theories of causation. But I ask you to put yourself in the shoes of the injured party and look at that practice again. The hospital's "win at all costs" attempts to deny that Cal had kernicterus cost us hundreds of thousands of dollars and delayed justice for years. The costs of the first trial were expenses we owed to our attorneys, in addition to a 40 percent contingency fee. That is just not right, and as his mother, I worry every day that Cal just will not be taken care of as he should be from the net award he received.

After more discovery and two mediations, we settled Cal's case. The process took 8 years. In the settlement process, I came under enormous pressure from my lawyers as well as the defendants' to sign a confidentiality agreement. I couldn't bring myself to do it. From the time Cal was diagnosed, I had been writing letters to the public health leaders in our country, trying to alert them to the fact that my son suffered what was then thought to be a freak accident in a hospital that delivers more than 5,000 babies a year. In the end, I promised not to name the hospital or discuss the amount of Cal's settlement in any communications, but retained the right to discuss his injury.

My husband's medical problems occurred after Cal's first trial. He had a tumor on his spine. We sought out one of the foremost spinal surgeons in the country to help us. After surgery, he gave us the good news that Pat's tumor was benign, congratulated us for dodging a bullet and told us to "Go home and live your lives." When another tumor grew, we returned to him immediately for a second surgery 6 months after the first. He was our hero; our hope and trust was in him.

As we prepared for the second surgery, we were met with strange questions about why Pat had not gotten follow up care for the first tumor. We explained our understanding that there was no need as Pat's tumor had been successfully removed and had been benign. In the conversations that ensued, we were led to believe that Pat's benign first tumor had somehow become cancerous. I am the one who discovered the pathology report that said Pat's first tumor was a sarcoma.

When Pat came to, I explained all that had happened and assured him that we were not going to relive the same experience we had in our home town, where we had been shunned by the healthcare system once we'd filed suit. But the truth was that we never saw Pat's surgeon again. We were discharged by a nurse, who stuck her head in the door and said, "You can go now."

When I called the pathologist who had signed the report to discuss what it meant, and why the pathology report was dated several weeks after the first surgery, he referred me to the patient ombudsman. I explained to this man that our family had been through litigation before, that we thought it was a dishonorable process and that whatever was to happen, we did not want to litigate. This approach was initially welcomed, and we agreed to continue to talk.

I believed the first response of this hospital to my request for open communication was sincere. However, after the insurance companies and legal counsel became involved, communication came to a screeching halt. We think the hospital and the surgeons' group, which had different insurers, wanted to preserve the right to point the finger at one another. Perhaps they wanted to wait to see if Pat would die. After being told not to contact them anymore because they could not talk to us, we filed a lawsuit on the last day of the statute of limitations period and entered into a 4-year litigation process.

Pat was subsequently treated at University of Texas M.D. Anderson Cancer Center, where everything was done to save his life. He died feeling betrayed by a doctor

who was once his hero—who disappeared instead of sitting down and talking with us.

Our claim against the hospital and surgeon also ended in settlement. Throughout the negotiation, I indicated that I would not sign a confidentiality agreement, and that I sincerely wanted to work with this hospital to prevent critical test care results from being lost for other patients. I think it is fair to say that my lawyers, and probably theirs, thought this was a naive request. From their point of view, this was about money. We were numbers, that was it.

I'm not sure that Pat's surgeon felt that way, however. As a condition of settlement, I asked to meet with the surgeon and the hospital CEO. I wanted to renew my request that we work together to prevent failures like this one from happening again. At the beginning of our meeting, I was told the surgeon would not be attending. His wife had called the CEO to say that he was too upset to talk to me.

As a result of my letter writing, I was invited to testify here in Washington at the first Agency for Healthcare and Research and Quality National Summit on Medical Errors and Patient Safety Research in September 2000 (accessible at http://www.quic.gov/summit/wsheridan.htm). *USA Today* wrote a story about my family. Within days, I was hearing from parents around the country who also had children with kernicterus. We connected some dots and figured out something the public health authorities had not—that kernicterus had re-emerged in the United States in the early 1990s after having been essentially eradicated. Public health officers at Centers for Disease Control and Prevention (CDC) were stunned. Hundreds of children had experienced kernicterus since the early 1990s, a function in part of early discharge and failure to educate providers and parents alike about the dangers of jaundice. All but a few cases had been effectively buried by confidentiality agreements—a condition of settlement insisted upon by doctors and hospitals that didn't want the bad publicity.

Within weeks, other moms and I were working together with anyone we could recruit to build a campaign to educate parents, change practice guidelines, increase public health surveillance and put kernicterus back in the history books where it belongs. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued a Sentinel Event Alert in 2001, the first ever generated as the result of a consumer-identified problem, (Kernicterus threatens healthy newborns, *Sentinel Event Alert*, Issue 18, April 2001, accessible at *www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_18*.htm). CDC followed shortly thereafter with a report in *Morbidity & Mortality Weekly*, (Kernicterus in Full-Term Infants—United States, 1994–1998, *MMWR*, June 15, 2001/50(23);491–4, accessible at *www.cdc.gov/mmwr/preview/mmwrhtml/mm5023a4.htm*). CDC has now identified kernicterus as one the three most serious emerging risks to newborns in the United States (See, *www.cdc.gov/ncbddd/dd/kernichome.htm*).

Through partnership with the Centers for Disease Control, the Joint Commission, the March of Dimes, National Institutes of Health (NIH), Health Resources and Services Administration (HRSA) and leaders in other countries, I believe we can accomplish that soon.

The expert witness who had 51 percent doubt about the cause of Cal's injuries was paid $34,000 for his half day of trial testimony. He was a member of the American Academy of Neurology, which is one of a handful of specialty medical societies that have a program to peer review its members' expert witness activities. I filed a grievance and was notified that I could attend as a silent observer the "nonadversarial" peer review process where this physician's conduct was to be reviewed. I did so, accompanied by another CAPS co-founder who was a former medical association attorney.

To our amazement, the physician brought as his counsel the hospital attorney who had hired him to be the expert in Cal's case. While I was prevented from saying a single word, the panel put no restrictions on the hospital attorney, who painted my family as calculating strategists trying to neutralize the doctor as a witness in Cal's new trial. Mind you, this was after the hospital had already dumped this expert's theory of the case and was preparing for the second trial on the assumption that Cal did have kernicterus. We could have brought out this duplicity if allowed to speak. Rather than being nonadversarial, this peer review process became a one-sided, duplicitous smear campaign unfolding before my eyes. It was a travesty. After the hearing, my colleague and I asked for a meeting with the American Academy of Neurology Board of Trustees to share with them our concerns about their peer review process. Numerous phone calls and three certified letters to their general counsel went unanswered.

I'm going to turn now from stories of the past to hopes for the future.

First, one of the mantra's of the patient safety movement is the need for transparency. It's ironic, but safety scientists refer to errors as "treasure" because they reveal the inherent weaknesses of our very complex healthcare delivery processes. As a mom, I cannot help but wonder whether Cal and many other kids like him could have been saved *or can be still saved* if our legal system was not so intent on burying its treasure. We must incentivize transparency. Finding a way to declare confidentiality agreements contrary to the public interest is an excellent place to start.

Second, we have done significant research and cannot find a single instance where medical societies or State licensing boards have disciplined an expert testifying on behalf of a defendant. The same financial incentives apply whether a physician is bending science for a hefty fee from the plaintiff or the defense. Our expert witness oversight is patchy at best, and apparently extremely one-sided. This is wrong and needs to be investigated. If specialty societies are going to take on the role of peer reviewing experts, they should be held accountable for doing it fairly. In addition, I know some of the specialized medical courts proposals anticipate an approach whereby experts will be called by and paid by the court, not the parties. That is an approach worth investigating.

Third, one of the by-products of the hand-to-hand combat approach to medical malpractice litigation is the tremendous variation between awards for patients and families with similar needs. There has been a kernicterus verdict in this country for close to $90 million dollars. Cal got a small fraction of that, and I know families who got a fraction of what Cal was awarded. Their children will inevitably become a burden to the Medicaid system. Justice should be equitable, and our case-by-case system does not work that way. So, whether it is a schedule of benefits or some other mechanism for giving juries or judges guidelines for reasonable awards, this fairness gap needs to be addressed.

If medical courts have rulemaking power and if they are overseen by those focused on consumer interests, I believe we could see damages reform that is much fairer than an arbitrary cap on pain and suffering. Medical associations that advocate arbitrary damage caps know that they disproportionately impact those claimants with the most severe injuries. We can come up with better solutions if we approach damages reform in a patient-centered way.

Fourth, the trial judge in Cal's case characterized our trial as a competition. Our own lawyers repeatedly told us it's a game. One of the mediators—a retired judge—referred to the jousting and sparring as a dance. At the mediation, several of the "dancers" were insurance actuaries and claims agents, complete with calculators. At every step, we were expected to go along, because this is the way it is done. As a mom—and a wife—and a citizen, I worry that too many people use these analogies to distance themselves from what is really supposed to be going on here: helping a family that has been harmed. To make justice a game is to dehumanize the people who seek it.

It is my understanding that the tort system was created for powerful, honorable, reasons—for the people. So I ask all of you involved in tort reform to follow these guidelines as you reshape the future of our tort system:

- Do it for the right reasons.
- Do not compromise the real interests of injured patients, which are fair compensation and honest investigations of what happened.
- Avoid the pressure to serve the interests of those professionals and organizations who are concerned more about their own finances than meeting the needs of the patients and clients they serve.
- Remember that people who experience medical error are not just dollar figures. We are your loved ones. We are you.

In closing, I ask you to use your power, your courage and your sense of justice to shape innovative programs that mark a return to integrity. Let's craft a system that uses our hard won treasure as a learning tool. Most importantly, let's truly serve the people who are relying on you, like daddies and babies.

Thank you. (Attachment: Exihibit 1: *Sheridan* vs *Jambura et al.* Memorandum Decision, district court of the foruth Judicial District of the State of Idaho, in and for the County of ADA, Case No. CV-PI 97-00266-D, July 19, 1999.)

[Editor's Note: Due to the high cost of printing, previously published materials submitted by witnesses are not reprinted in the hearing. You may see the attachment referred to above at www.patientsafety.org]

The CHAIRMAN. Ms. Niro.

Ms. NIRO. Good morning, and thank you for the opportunity to present the views of the American Bar Association, the ABA. My

name is Cheryl Niro. I am one of the first lawyers in Illinois to become a mediator and arbitrator.

I learned my skills at various institutions across the country, beginning with the Atlanta Justice Center, which was one of the first mediation programs in the country. I have been both a student and a teaching assistant at the Harvard Law School Mediation and Negotiation Training Programs. Over the years, I have mediated hundreds of cases successfully and trained both lawyers and judges to use those methodologies.

I have, more importantly, trained healthcare professionals to use negotiation and mediation skills to resolve medical disputes with patients and their families at bedside, a program which has great potential to lower subsequent filing of malpractice claims. I have never filed a plaintiff's medical malpractice case in my long career as an attorney.

Mediation, by definition, is a voluntary process, whereby disputants work together with the assistance of a trained mutual facilitator to resolve disputes. Mediators, by ethical requirements, are prohibited from imposing a resolution on the parties. The ethical use of arbitration must also be premised on a knowing agreement to arbitrate as well.

The ABA has reviewed proposals related to the area of healthcare liability. One such proposal is the creation of health courts. As we understand it, an administrative agency would oversee these courts. Judges and juries would be replaced by persons experienced in healthcare. Injured patients would then have no access to the court system or a trial by jury or the rules of procedure and the rules of evidence. Expert witnesses would be hired by the health court, and injured patients would be compensated according to a schedule of awards.

Proponents say that the health court scheme is modeled after workers compensation. There is a significant difference, however. Injured workers do not have to prove liability. This legal burden was removed by the workers compensation system to balance their loss of right to bring an action in court, and it is that balance that provides the integrity and the fairness to our national system of caring for citizens who have been injured in the workplace.

No such balance or appearance of fairness is present in a health court scheme. Injured persons lose their constitutionally protected right to a trial by jury, but they retain the legal burden of proving negligence, as if they were in a court. If they meet the burden, they are compensated according to a schedule of awards, which would treat all injuries the same. The ability of all judges and juries to fashion an award based on the unique facts of each case would be lost.

It's sad to me that what makes proven alternative dispute resolution methods like mediation so very attractive is that the parties who use those methodologies actually get to participate in crafting a unique agreement to resolve it. In health courts, I believe and fear that the exact opposite would result. The great potential of mediation as an alternative to litigation would be lost to a system that wouldn't possess the ability to see the injured patient as a person, a very unique person.

There is something not quite humane about a healthcare program that would treat us only as a collection of similar injuries and body parts. Moreover, I fear that predetermined awards are just caps in disguise and are just as unfair. Caps have been found unconstitutional in at least 13 States, and they work to disadvantage women and children and the elderly, typically our most vulnerable citizens.

That situation only becomes more disturbing when one imagines that some of these patients may be forced to agree to submit their dispute to a health court before they receive treatment, or even worse, as a condition for receiving treatment.

The ABA opposes any health court proposal that would prevent an injured patient from having access to a trial by jury presided over by an independent judiciary and would place an arbitrary cap on damages. We do support the ethical use of other alternatives to litigation, such as negotiation, mediation, and settlement agreements, and believe that great potential for innovation would be enhanced by our legal and medical communities working collaboratively to create new methodologies that preserve the constitutional rights of our citizens.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Ms. Niro follows:]

PREPARED STATEMENT OF CHERYL NIRO

SUMMARY

The American Bar Association has supported the use of and experimentation with voluntary alternative dispute resolution methodologies as welcome components of the justice system, provided the disputant's constitutional and other rights and remedies are protected. The appropriate use of these voluntary alternatives to litigation is growing across the country and is becoming an important part of our system of justice. The ABA has contributed to the growth of this field by creating ethical standards, conducting training in ADR skills, and convening ADR professionals in ABA-sponsored programs.

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. In order to protect the rights of injured patients, alternative dispute resolution must be voluntary.

The American Bar Association opposes the creation of "health courts" as proposed in recent legislation. Under this proposal, medical malpractice cases would be removed from the court system and placed in health courts operated by an administrative agency. Judges and juries would be replaced by fact-finders with training in science or medicine. No procedural protections have been defined. Injured patients would be forced to give up their right to a jury trial.

In the "health courts" proposal, a schedule of awards would be established, similar to the Workers' Compensation system. But unlike the Workers' Compensation system, injured patients would still be required to prove liability, whereas injured workers obtain a guaranteed award in a no-fault system for waiving their right to a jury trial. The schedule of awards is a *de facto* cap on noneconomic damages and, for that reason, could well be found unconstitutional. The ABA opposes legislation that places a dollar limit on recoverable damages and operates to deny full compensation to a plaintiff in a medical malpractice action. The ABA 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. The ABA also opposes the creation of healthcare 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 supports the tradition of trial by jury. Empirical studies have demonstrated that juries are competent in handling medical malpractice cases.

The court system can improve the management of medical malpractice cases and make appropriate voluntary use of alternative dispute resolution methodologies while protecting the rights of injured patients to access the courts. The ABA requests that Congress reject the proposed health court legislation.

Mr. Chairman and members of the committee, I appreciate the opportunity to present the views of the American Bar Association (ABA) on "Medical Liability: New Ideas for Making the System Work Better for Patients." 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 U.S. 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 15 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 healthcare providers. One such proposal is the creation of "health courts." Under the proposed "health court" system, an administrative agency would oversee the oper-

ation of specialized "courts" where medical malpractice cases would be heard by persons possessing experience in the healthcare 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 noneconomic 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 noneconomic 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 noneconomic 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 healthcare 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 percent 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 healthcare 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 healthcare 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 $20, the right of trial by jury shall be preserved, and no fact tried by a jury shall be otherwise re-examined 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]

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 na-

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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).

tions 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 healthcare 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.

The CHAIRMAN. Mr. Vidmar.

Mr. VIDMAR. Thank you very much, Senator. Let me suggest——

The CHAIRMAN. I don't think your microphone is on. There; thank you.

Mr. VIDMAR. Thank you very much, Senator, and the rest of the committee for this opportunity to speak.

I want to introduce my comments with two points. One is my position on these matters is almost, well, not almost, is synonymous with that of the American Bar Association, which Ms. Niro has just spoken. I support ADR as long as it is voluntary with full awareness of the consequences and after a dispute has occurred, and in fact, I should indicate that I started Duke's program on negotiation and mediation at the law school, which most of our students then take; in fact, 80 percent of them, so I am a strong supporter of mediation and alternative ways of handling disputes.

I have been studying medical malpractice litigation for 2 decades. I have sat through trials, interviewed jurors, and the lawyers and the plaintiffs and the defendants in these cases. I have conducted jury experiments. I have had access to closed claims files from insurers and interviewed insurance adjusters. Recently, work that I have done with Florida, closed claims from the Florida Department of Insurance, has been conducted with a colleague who is an M.D. in the Duke medical school.

I have also had a unique opportunity to observe real juries in operation. The Arizona U.S. Supreme Court allowed an experiment that will never be repeated again, probably, in which I have actually videotaped the deliberations of 50 civil juries. I have seen those juries deliberating and the way that they operate, so I have some unique experience in this.

In this regard, Senator, I will stand up and defend the tort system. It is not perfect. It has a lot of costs, but I agree with the New England Journal of Medicine study which Professor Studdert has

talked about, that the claims of frivolous litigation are vastly overblown; that the tort system performs reasonably well.

And those conclusions, and I have a 31-page document that I have submitted in my written testimony for this, in which I try to summarize at least many of those findings are totally consistent with those conclusions from the New England Journal of Medicine.

What I can tell you is that juries, from the research that I have done, are intelligent, conscientious, follow the legal rules and instructions, and it is trial by jury, and judge and jury, and the judges who sit on the side of those trials every day have the greatest respect for the jury. The studies that have been done with them show those kinds of consistencies, and the judges give them very high marks.

The research also shows that verdicts correlate with the judgments of medical professionals; the New England Journal of Medicine study, which is the most recent and probably the very best study, but there are previous studies that have also shown that same kind of correlation.

Now, I have covered a lot of topics in my written testimony, and let me just touch on two here. One is that the caps that have been discussed to me are unfair for the reasons that have already been discussed. They discriminate against the most severely injured patients. They discriminate against women, children, and the elderly, and they are also unfair in another sense. If an individual is hurt in an automobile accident this afternoon, they are entitled to fair and just compensation, individualized justice, by the right to trial by jury if, in fact, they cannot settle the case.

Under the proposals that are being set forward now, the person who is injured by medical negligence, who is just as injured as anyone else, does not have the same right, and this seems to be ignored in so much of this discussion about the medical negligence system, and lots of people are deeply hurt.

And in fact, this morning, in preparation for coming here, I arrived early, and I sat on the steps of the U.S. Supreme Court, and I looked up at the heading, individualized justice under law [sic]. And that's what our jury system provides, because when you have caps, you can't really describe all of the kinds of variations that go on in these cases. Somebody who is injured in one way or another way, the range of hurt is very difficult, and that's why we have relied upon those systems. So individualized justice under law is what is actually provided by the jury system, which we've relied on before we even had a Constitution.

The proponents of streamlined procedures, I want to comment on, really have failed in many ways to realize the complexity, because I have worked in the trenches and studied the trenches. I am a social psychologist by training, and I have talked to lawyers. These are not easy cases, the serious ones that really, you know, the very serious injuries, these are not easy cases to resolve, because each side disputes what is going on. And I think that when we look at these alternative systems, one of the things that we have to ask ourselves is: Can they do it in these very efficient ways, especially if the system is designed to be fair?

So I think we need to look at it very carefully. The assumption seems to be that these other systems will be fair, but when you

have experts appointed by judges, you have people who are administrative judges who can become cynical in the way they handle these things, because you can also have changes that these administrative systems will be subjected to potential political pressure, including the pain and suffering.

And this is one of the things that I want to make a comment about: the defined payment schedules under these healthcare systems, and I can elaborate that later in other comments in the healthcare courts, are very similar to the problem with caps on pain and suffering. You have exactly the same kind of problem that they do not provide that individualized justice, and scheduling will just not solve the problems.

Finally, again, I covered a lot of material in my lengthy submission here. I want to just make one final comment about the doctors' exodus and so forth. You know, these are political kinds of problems on both sides, and I am sympathetic to doctors. In fact, I feel strongly that the cutbacks in Medicare and Medicaid have really harmed our doctors, and I think Congress bears some responsibility for this, and I talk to doctors a lot, and it really has affected the healthcare system, and that has not been discussed here today, and I think that plays an important part, and in fact, I think as a taxpayer, I would be willing to pay a little bit more taxes to help out the doctors.

But these claims that there's a big doctor's exodus, the judicial hellholes from near my hometown of Gillespie, Illinois; that is Edwardsville and St. Clair, you know, the comment was that doctors are leaving; 26 percent of the doctors have left the area. Research that I did for the Illinois State Bar Association, I went and looked at the data. I used the statistics from the American Medical Association and actually found that the area had actually gained doctors, not lost doctors, and just recently, a report that was just released this week, I looked at the same issue in Pennsylvania, and surprise? No, I am not surprised that Pennsylvania has actually gained doctors despite the claims that Pennsylvania lost one quarter of their doctors.

And I think we need to look at this in the whole context of things, and that also hasn't been discussed today, that these things get very clouded, the attacks on the jury system and the tort system. It's not perfect, but many of the claims, I think, are misdirected.

Thank you for your attention.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Vidmar follows:]

PREPARED STATEMENT OF NEIL VIDMAR

SUMMARY

• Empirical research contradicts mythology about the tort system in medical malpractice litigation.

• Medical injuries resulting from medical negligence are a serious problem and have high economic and emotional costs for injured patients.

• The tort system performs well in separating meritorious and nonmeritorious claims.

• Research shows that jury verdicts are not biased against doctors, that they are consistent with judgments of medical experts, the opinions of trial judges that they are not "overwhelmed" by plaintiff's experts and that awards positively correlate with plaintiffs injuries and economic losses.

• Caps on so-called "noneconomic" damage awards are unfair and do not reduce medical liability insurance premiums. "Defined payment schedules" in some proposed alternatives to jury trial suffer from the same problems as caps.
• Claims about "frivolous litigation" are not supported by empirical research.
• Research on closed claims show that allegations about increased litigation costs are not supported.
• Claims about a "doctor exodus" from States alleged to have "an abusive litigation climate" are contradicted by official statistics of he American Medical Association.

MY BACKGROUND

I am Neil Vidmar, I hold the Russell M. Robinson II Professor of Law chair at Duke Law School. I received my Ph.D. in Psychology from The University of Illinois (1967). At Duke I also have a joint appointment in the Department of Psychology. I have published over 100 articles in scholarly journals and several books. A new book, *American Juries*, will hopefully be completed this summer.

I have been conducting empirical research on medical malpractice litigation since I came to Duke Law School in 1987. Under support from the Robert Wood Johnson Foundation, The State Justice Institute and other sources, I published a number of articles on medical malpractice in the 1990s. This research and other studies were combined into my book, *Medical Malpractice and the American Jury: Confronting the Myths about Jury Incompetence, Deep Pockets, and Outrageous Damage Awards*. (University of Michigan Press, 1995).

I have continued to conduct research on that subject and have published the following articles and reports since that book was published: Vidmar, N., Gross, F., & Rose, M. *Jury Awards for Medical Malpractice and Post-verdict Adjustment of Those Awards*. 48 DePaul Law Review 265 (1998); Vidmar N. and Brown, Leigh Ann, *Tort Reform and the Medical Liability Insurance Crisis in Mississippi: Diagnosing the Disease and Prescribing a Remedy* 22 Mississippi College Law Review 9–46 (2002); Neil Vidmar, Juries and Jury Verdicts in Medical Malpractice Cases: Implications for Tort Reform in Pennsylvania, January 28, 2002; Vidmar, (Book Review) *First, Do No Harm: The Cure for Medical Malpractice*, 352 The New England Journal of Medicine 521 (2/3/2005); Vidmar, Lee, MacKillop, McCarthy and McGwinn, *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DePaul Law Review 315 (2005); Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, the Contingency Fee System, Juries and Social Policy*, 38 Loyola Los Angeles Law Review 1217 (2005); Vidmar, Medical Malpractice and the Tort System in Illinois: A Report to the Illinois Bar Association, May 2005; Vidmar, *Medical Malpractice and the Tort System in Illinois*, 93 Illinois Bar Journal 340 (2005); Vidmar, MacKillop and Lee, *Million Dollar Malpractice Cases in Florida: Post-verdict and Pre-suit Settlements*, Vanderbilt Law Review (in press, 2006); Vidmar and MacKillop, *"Judicial Hellholes:" Medical Malpractice Claims, Verdicts and The "Doctor Exodus" in Illinois*, Vanderbilt Law Review (in press, 2006); Vidmar. *Medical Malpractice Litigation and Tort Reform in Pennsylvania: A Report for the Pennsylvania Bar Association*, May 2006.

I am appearing here today to provide this committee with my professional knowledge of medical malpractice litigation. I am receiving no remuneration for my testimony. My travel expenses are being reimbursed from my Duke Law School faculty account. The opinions that I offer are, however, my own and are not necessarily those of Duke Law School or Duke University.

In May of this year the *New England Journal of Medicine* published an article authored by researchers associated with the Harvard School of Public Health that closely examined 1,452 closed medical malpractice claims in four areas of the United States.[1] Their main conclusions merit direct quotation:

> 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 direct system costs by 13 percent . . . to 16 percent. 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 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.[2]

These conclusions are a good starting point to address issues about medical malpractice litigation. They are consistent with my own research findings and that of other researchers.[3]

SOME PROPOSALS FOR ALTERNATIVES OR CHANGES TO THE TORT SYSTEM WOULD ABOLISH OR SEVERELY CURTAIL THE CONSTITUTIONAL RIGHT TO TRIAL BY JURY

Some of the proposed experimental programs in the proposed Fair and Reliable Medical Justice Act (S. 1337), 109th Cong. (2005) would force patients to enter into an administrative scheme without the right to trial by jury: e.g. The Administrative Determination of Compensation Model and the Special Health Care Court Model.

The proposal for Health Courts developed by Common Good and the Harvard School of Public Health[4] also raise issues about constitutional rights.

Voluntary resolution procedures, such as those discussed by Senators Clinton and Obama in the *New England Journal of Medicine*[5] do not raise these constitutional issues.

I will not address the constitutional issues in my testimony, though I do want to call attention to the fact that the Seventh Amendment to the U.S. Constitution and the constitutions of the 50 States provide all citizens the right to jury trial for all common law civil claims.

Rather I want to address the commonly held myths that have been raised about the tort system and in particular the jury system. Empirical research evidence strongly goes against these myths.

MYTHS ABOUT THE TORT SYSTEM IN MEDICAL MALPRACTICE CASES

The commonly perpetrated myths about the tort system, in no particular order, are as follows:

- Jury verdicts constitute the major source of costs for medical liability payments and defense expenses.
- Jury verdicts drive the settlement process.
- Jury verdicts are biased against doctors on the issue of liability, either due to prejudice against doctors or because juries are confused and misled by plaintiff medical testimony.
- Juries are driven by sympathy for plaintiffs rather than the evidence.
- Jury damage awards are excessive and not rational.
- The major portion of jury damage awards are for "general damages" (also, inappropriately labeled "noneconomic damages" or simply "pain and suffering."
- Caps on pain and suffering will reduce health providers' liability insurance premiums.
- Jury awards and their fallout are driving doctors from States without caps on "pain and suffering."
- Many lawsuits are frivolous and driven by the expectation that a jury will award mega damages.
- The cost of defending frivolous cases has increased.

I want to address these myths by describing what research findings demonstrate.

MEDICAL INJURIES FROM NEGLIGENCE ARE A SERIOUS PROBLEM

The Harvard study of medical negligence examined hospital records of 31,000 patients and concluded that 1 out of every 100 patients admitted to hospitals had an actionable legal claim based on medical negligence.[6] Some of these patients' injuries were minor or transient, but 14 percent of the time the adverse event resulted in death and 10 percent of the time the incident resulted in hospitalization for more than 6 months. Significantly, 7 of those 10 persons suffered a permanent disability. Generally, the more serious the injury the more likely it was caused by negligence.[7] Subsequent research involving Utah and Colorado found rates of negligent adverse events that were similar to the New York findings.[8]

There are reasons to believe that the Harvard study may have underestimated the incidence of medical negligence because the data were based solely on hospital records. Andrews conducted a study in a large Chicago-area hospital and studied actual incidence of negligent events in hospital wards.[9] Andrews discovered that many injuries were not recorded on the records as required, especially when the main person responsible for the error was a senior physician. Other research is consistent with the Andrews's findings.[10]

In 2000, the Institute of Medicine produced a report that relied on these studies and other data.[11] The report concluded that each year 98,000 persons died due to medical error and that many other patients sustain serious injuries.

In 2004, HealthGrades, Inc., a company that rates hospitals on healthcare for insurance companies and health plans, studied Medicare records in all 50 States for the years 2000 to 2002.[12] HealthGrades concluded that the Institute of Medicine's figure of 98,000 deaths was too low and that a better estimate was 195,000 annual deaths. In addition the HealthGrades report estimated that there were 1.14 million "patient safety incidents" among 37,000,000 hospitalizations. HealthGrades further concluded that "[o]f the total 323,993 deaths among Medicare patients in those years who developed one or more patient-safety incidents, 263,864, or 81 percent, of these deaths were directly attributable to the incidents" and that "[o]ne in every four Medicare patients who were hospitalized from 2000 to 2002 and experienced a patient-safety incident died."

In 2005 HealthGrades released another annual report that found 1.24 million total safety incidents.[13] The report concluded that "for the second year in a row, patient safety incidents have increased—up from 1.14 and 1.18 million reported in HealthGrades' First and Second Annual Patient [reports]." The report further concluded that "Of the 304,702 deaths that occurred among patients who developed one or more patient safety incidents, 250,246 were potentially preventable."

It is important to note that the patient error rates reported in the IOM and the Healthgrades reports do not always mean that negligence was involved. Additionally, some critics have charged that the various estimates in these studies are too high.[14] However, there is no serious question that medical negligence not only occurs, but that it occurs at a substantial rate.

INJURIES DUE TO MEDICAL NEGLIGENCE HAVE HIGH COSTS

More than a dozen years ago, Frank Sloan and Stephen van Wert, two economists, conducted systematic assessments of economic losses (medical costs, income losses, and other expenses) in Florida cases involving claims of medical negligence that occurred as a result of birth-related incidents.[15] Even though those researchers offered the caution that their assessment procedures probably underestimated losses, severely injured children's economic losses were, on average, between $1.4 and $1.6 million in 1989 dollars. If adjusted for inflation using the consumer price index, these figures in 2005 dollars translate roughly to $2.3 million per case. In the same study, the losses of persons who survived an emergency room incident were estimated at $1.3 million per case, or $ 2.1 million in 2005 dollars. For persons who died in an emergency room incident, the loss to their survivors was estimated at $0.5 million, which translates to $0.8 million in today's dollars. It is important to note that there was considerable variability in these estimated averages: some patients had much higher economic losses and, conversely, others had lesser economic losses.

Sloan and van Wert's estimates, moreover, did not consider "noneconomic" losses, such as pain and suffering, disfigurement or loss of enjoyment of life's amenities. So-called "noneconomic" losses in fact often have economic consequences as State courts have recognized.[16] Disfigurement or "loss of a normal life," for example, may affect employment or marriage opportunities.

A more recent study of Florida closed claim data that I and my colleagues conducted[17] indicated that the average payout for a permanent significant injury such as deafness, loss of a limb, loss of an eye or one kidney or lung in 2003 dollars was $601,828. For a permanent major injury such as paraplegia, blindness, loss of two limbs or brain damage, the payout was $601,828. For a grave injury such as quadriplegia, severe brain damage, lifelong care or a fatal prognosis, the average payment was $694,427. The range of payments within these categories was considerable; sometimes the payments were many times the average payment. This should not be surprising. A young person requiring lifelong care will cost more than an aged person requiring lifelong care. A professional or a business executive will have greater lost income than an unskilled worker.

ONLY ONE OUT OF SEVEN INJURED PATIENTS SUES

There is a widespread belief that injured patients sue at the drop of a hat or because they are persuaded to do so by rapacious plaintiff lawyers. In fact, the opposite appears to be true. One of the most striking findings from the Harvard medical malpractice project is that seven times as many patients suffered from a medical negligence injury as filed a claim.[18] Put in different words, for every seven patients who suffered a negligent injury, just one claim was filed. Claims were also filed in cases in which the research team of healthcare providers concluded that there was no negligence. However, the bottom line is that for every doctor or hospital charged with a claim where no negligence was found, there were as many as seven valid claims that were not filed.[19]

There are a number of explanations as to why the rate of claiming for negligent medical injuries is about one in eight. The plaintiff may never suspect that negligence has occurred or may never be told that the outcome was due to negligence. The patient may be told that an error occurred, but that the medical provider corrected the injury. Even if the error cannot be corrected, the patient, or his or her heirs in the case of a wrongful death, may be reluctant to sue because the medical provider is well-liked or offers an apology.

Another important reason is that a patient may not be able to find a lawyer to represent him. Sloan and Hsieh studied 220 childbirths in Florida in 1987 that involved death or permanent injury to the child.[20] The researchers had physicians independently review the files and determine if negligence had taken place. The families of the children were interviewed. Of the 220 cases, 23 parents sought legal advice. These tended to be cases in which the child suffered very serious injuries and independent reviewing physicians had concluded that negligence was probably involved. However, not a single suit was filed in any of the 220 cases. Sloan and Hsieh concluded that:

> The lack of claimants among the 220 women whose babies had serious birth-related injuries and the failure of 23 women to obtain [legal] representation runs counter to the "conventional wisdom" that patients sue when they obtain less than a "perfect result." In fact, lawyers filter out many potential claims that injury victims might lose.[21]

Research by Herbert Kritzer examined the decisions of plaintiff lawyers to take or decline cases.[22] Kritzer found that because lawyers working on a contingency fee basis have their own time and money at stake, they tend to very carefully screen cases and weed out those that have minor injuries, low damages potential, or that have a low potential of winning at trial. In ordinary cases, lawyers may decline as many as 9 cases in 10; in medical malpractice cases, the proportion of declined cases may be even higher. Economic reality drives lawyers' decisions to accept or reject cases. Kritzer's research findings are consistent with those of Sloan and van Wert.

Combined with the factors of patients not discovering that they are victims of negligence or patients' reluctance to sue even if negligence is discovered, plaintiff lawyers' screening of cases helps explain the low-claiming rates found in the Harvard study and subsequent studies. Patients who find a lawyer and file lawsuits are more likely to have suffered a serious injury and have a reasonable likelihood of prevailing on liability and demonstrating serious economic damages.

MYTHS THAT ARE PERPETUATED ABOUT JURIES

Are juries as irresponsible and incompetent as tort reform critics say they are? Are jury decisions responsible for medical malpractice insurance premium hikes? The results of more than 3 decades of systematic research by many scholars are not consistent with these claims. Critics of juries usually make their charges through anecdotes that are nothing more than urban legends. *They ignore many research findings that doctors win between 6 or 7 out of 10 cases that go to trial, that damage awards are related to the severity of the patient's injury and that only a small percentage of malpractice payments result from jury trial.*

TRIAL BY JUDGE AND JURY

"Trial by jury" is misleading. It is "trial by *judge* and jury." The trial judge presides over the trial, determines which evidence is allowed and which is not. The judge hears and sees the same evidence as the jury. Before the jury's verdict can be recorded as a legal judgment, the trial judge must agree that the evidence was sufficient to support the verdict. If the judge disagrees on the issue of negligence, he or she can set aside all, or parts, of the verdict. If the judge believes that the amount of damages is too high, the amount can be reduced through the legal device called "*remittitur*." If the plaintiff is unwilling to accept the judgment, the judge can order a new trial.

PLAINTIFFS LOSE MOST JURY TRIALS

Many studies have examined win rates in medical malpractice trials. The findings contradict widespread beliefs about jury verdicts. For example, the Bureau of Justice Statistics systematically sampled jury verdicts in 1992, 1996, and 2001 in courts representing the 75 most populous counties in the United States.[23] There were 1,156 medical malpractice cases in the sample, and 96 percent of these were tried before juries. In 1992, plaintiffs won 30.5 percent of jury trials, but in 2001, the win rate had dropped to 26.3 percent, roughly one case in four. Win rates vary slightly by State and by counties within States. The fact that doctors win two-thirds of the

cases filed is not evidence that these suits are frivolous cases. These are cases where a judge concluded that a legitimate triable issue, a factual dispute, existed between the parties.

JURORS VIEW PLAINTIFF CLAIMS WITH SKEPTICISM

The assertion that jurors decide cases out of sympathy for injured plaintiffs rather than the legal merits of the case is one of the most persistent claims of opponents of civil jury trial. Research finds little support for these claims.

Interviews with North Carolina jurors who decided medical malpractice cases showed that jurors viewed the plaintiffs' claims with great skepticism.[24] Jurors expressed their attitudes in two main themes: first, too many people want to get something for nothing, and second, most doctors try to do a good job and should not be blamed for a simple human misjudgment. This does not mean that in every case jurors held these views. Sometimes, evidence of the doctor's behavior caused jurors to be angry about the negligence. However, even in these latter cases the interviews indicated that the jurors had approached the case with open minds. Hans interviewed jurors who decided tort cases, including medical malpractice, and obtained similar findings.[25] Hans concluded that jurors often penalized plaintiffs who did not meet high standards of credibility and behavior, including those who did not act or appear as injured as they claimed, those who did not appear deserving due to their already high standard of living, those with pre-existing medical conditions, and those who did not do enough to help themselves recover from their injuries.

NO EVIDENCE FOR THE "DEEP POCKETS" CLAIM

Closely related to the claim of "jury sympathy" verdicts is the claim that juries are more likely to render verdicts against doctors, hospitals, and corporations, not because they are seen as negligent, but only because the jurors perceive them as having the ability to pay large awards—a so-called "deep pockets" effect. A number of research studies have assessed this hypothesis and find no support for it.[26]

JURY VERDICTS AGREE WITH JUDGMENTS OF NEUTRAL MEDICAL EXPERTS

An important study of medical malpractice litigation by Taragin et al. compared jury verdicts with the opinions of doctors hired by an insurance company to review the medical records to provide a neutral assessment of whether they believed medical personnel had acted negligently.[27] The review decisions were confidential and could not be obtained by the plaintiff or used at trial. The research team compared the doctors' ratings with jury verdicts. The verdicts tended to be consistent with these assessments. Moreover, the study also found that juries' decisions on liability or negligence of doctors were not correlated with the severity of the plaintiff's injury. *The results, therefore, contradict the claim that juries decide for the plaintiff out of sympathy rather than apply the legal standard of negligence.*

The *New England Journal of Medicine* study that I referenced at the beginning of my testimony is consistent with the Taragin et al. research. Juries tended to reject claims that had no merit.[28]

JUDGES AGREE WITH JURY VERDICTS

Some studies asked trial judges to make independent assessments of who should have prevailed in civil cases over which they presided.[29] The judgments were made while the jury was still deliberating and, therefore, were not contaminated by knowledge of the outcome. The judge's decision was then compared to the jury verdict in that case. Although the research did not specifically focus on malpractice juries, the findings indicate that there was high agreement between the judge and the jury. Moreover, in instances when the judge would have decided differently than the jury, the judge usually indicated that, nevertheless, the jury could reasonably have come to a different conclusion from the trial evidence. Other studies asked large national samples of judges to draw on their professional experience with juries and give their opinions about jury decisions.[30] The surveys uncovered a general consensus that jurors accept and take very seriously their civic responsibility. The overwhelming number of the judges gave the civil jury high marks for competence, diligence, and seriousness, even in complex cases.

JURIES ARE NOT "OVERWHELMED" BY PLAINTIFF'S EXPERTS

An often-repeated charge is that the plaintiff's experts in medical malpractice cases overwhelm jurors.[31] This confusion and deference to experts, it is alleged, plays to the advantage of plaintiffs because the jury simply defers to the plaintiff's experts and allows juror sympathies for the plaintiff to be the basis of their verdict.

There is fuzzy logic in this claim, however, because it ignores the fact that defendants also cross-examine plaintiff's experts and call their own experts who offer opinions contrary to the plaintiff's experts. Moreover, the defendants often call more experts than the plaintiff.

Systematic studies of jury responses to experts lead to the conclusion that jurors do not automatically defer to experts and that jurors have a basic understanding of the evidence in malpractice and other cases.[32] Jurors understand that the adversary system produces experts espousing opinions consistent with the side that called them to testify. Moreover, jurors carefully scrutinize and compare the testimony of opposing experts. They make their decisions through collective discussions about the evidence.

DAMAGE AWARDS CORRELATE WITH SEVERITY OF INJURY

Bovbjerg et al. found that the magnitude of jury awards in medical malpractice tort cases positively correlated with the severity of the plaintiffs' injuries, except that injuries resulting in death tended to result in awards substantially lower than injuries resulting in severe permanent injury, such as quadriplegia.[33] I and two colleagues conducted a study of malpractice verdicts in New York, Florida, and California. We also found that jury awards of prevailing plaintiffs in malpractice cases were correlated with the severity of the injury.[34] In these studies, there was variability of awards within levels of injury. However, economic losses vary by patient. The economic loss for a quadriplegic who is 40-years old with a yearly income of $200,000 and a family of three young children would ordinarily be much greater than an identical quadriplegic who is retired, widowed, 75-years old, has no dependents, and whose annual income never exceeded $35,000. Moreover, losses can vary by a given location because the costs of living, including the costs associated with medical care and treatment, are higher in urban areas compared to rural areas.

JURY DAMAGE AWARDS HAVE INCREASED, BUT THERE ARE PLAUSIBLE, RATIONAL REASONS

The Bureau of Justice Statistics study found that in 2001 the median verdict in medical malpractice trials when plaintiffs prevailed was $431,000, compared to $253,000 in 1992.[35] Punitive damages were awarded in 4 percent of cases, and those tended to involve cases of gross malfeasance, such as sexual assaults on patients. Most State laws proscribe punitive damages in malpractice cases except for cases involving fraud, or wanton and willful behavior. My own research in Florida, involving a study of closed claims compiled by the Florida Department of Insurance also showed that awards increased between 1990 and 2003.[36] Claims have been made that this increase is due to increased jury profligacy, but there are very plausible alternative explanations.

A study of the Texas closed claim data base over a 15-year period by Charles Black and his co-authors found the medical malpractice system was largely stable and generated few significant changes in claim frequencies, payments, or jury verdicts. The authors concluded that "Average payments on medical malpractice claims rose because small claims were squeezed out of the system over time, not because payments on larger claims increased."[37]

Patients may have sustained more serious injuries. Due to medical advancements, patients can survive negligent injuries for longer periods of time than in the past, and thus their medical bills have increased. For example, only a few years ago many brain injured babies died. Today, thanks to medical advancements those babies now live, but at enormous medical expense. Our society must and should support those children, but the costs can sometimes be astronomical.

Another explanation may lie in the possibility that plaintiff lawyers have become more adept at "proving" damages by using experts who document economic losses better than in the past.[38] An additional possible cause is that the cost of negligent medical injuries and lost income may have increased. During the 1990's, medical costs, and consequently cost for needed medical care, increased 51.7 percent and general inflation, which is reflected in lost wages, increased 26.2 percent.

Another explanation for the increase in costs is that cases with claims of more serious injuries may be tried to juries in 2001, compared to 1992. This last possible explanation needs elaboration. The study of medical malpractice litigation in Florida that I and my colleagues conducted found that, compared to the first 3 years of the 1990s, during the first 3 years of the 2000-decade, there were more settled cases involving claims of negligent deaths and fewer cases involving less serious injuries. The change in types of cases is unlikely to explain all of the increase in awards, but it does appear to be a possible partial explanation.

In short, like many other parts of the medical malpractice controversy, the questions about damages are complex, and at present there are not satisfactory answers to all of these questions.

SOME EXAMPLES OF INJURIES FROM MEDICAL NEGLIGENCE

Statistics do not tell stories of injuries as well as case examples. I offer some recent examples of jury verdicts from Philadelphia, although I can equally provide other examples from Florida and Illinois. The examples provide graphic illustrations of the sometimes catastrophic injuries suffered by patients as a result of medical negligence.

Table 1.—Sample of Claims and Awards in Philadelphia's Million Dollar Cases Occurring Between July 2003–December 2004

Case Number	Verdict Date	Injury Claim	Verdict
10400199	9/18/03	In 1984, at 3 weeks old this female had surgery for hip dysplasia and suffered damage to her femoral nerve. At age 19, she suffers permanent physical pain, disability, disfigurement and has had to spend money for hospitalization, medication, treatment and rehabilitation.	$1,000,000
10301115	9/30/03	Doctor failed to diagnose an intra-cranial tumor in female, resulting in loss of hearing in one ear, resulting in additional surgery, diminution of earning potential, pain and emotional distress; $37,500 to husband for loss of services, companionship.	$1,500,000
10201487	10/02/03	Female lupus patient with dialysis in severe pain, but doctors failed to conduct tests and gave improper medication and discharged patient who became a quadriplegic plus multiple hospitalizations and future medical costs.	$8,178,350
10402583	10/28/03	Male, age 19, was in hospital after suicide attempt. Intensive care nurses failed to respond in timely manner to bedside monitor alarm, resulting in severe brain damage. $600,000 in past medical expenses and life care estimated at $6 to $12 million. Punitive damages of $15,000 for nurse altering records.	$10,015,000
10600976	11/17/03	Male, age 37, with two children, earning $60,000 per year; elective surgery for hearing loss and died almost immediately upon administration of anesthesia.	$2,910,000
10601622	11/25/03	Female, age 61, examined for gastrointestinal bleeding, but doctors failed to diagnose cancerous tumor until 2 years later and woman dies.	$1,000,000
10800103	12/03/03	Female, age 55, claimed failure to diagnose and treat liver disease that resulted in liver cancer. Plaintiff underwent four hospitalizations, had end-stage liver disease at time of trial, and was seeking a liver transplant.	$1,800,000
10500659	12/23/03	Female, age 48, dies after failure to diagnose and treat adrenal insufficiency over an 8-year period despite more than 40 visits to doctor.	$1,000,000
10702977	1/30/04	Pregnant female, age 34, in auto accident causing injured ankle; surgery performed after birth with bone graft and screws. Claims of lack of informed consent and result of severe, permanent injuries to bones, muscles, nerves and blood vessels in right leg with permanent pain, depression, and inability to care for her child plus additional surgeries and nursing care.	$15,000,000
10300103	2/06/04	Female, age 39, suffering gastrointestinal problems had bowel surgery and surgeon severed her bile duct that could not be repaired, resulting in permanent pain and spasms, gastroparesis, motility and risk of progressive liver disease, possibly needing a liver transplant.	$20,500,000
98060057	2/11/04	Female, age 30, had corrective surgery to ureter which was accidentally severed and repaired improperly; ureter placed on top of bladder instead of side resulting in reflux disorder, chronic kidney infection and will probably require kidney removal.	$9,000,000

Table 1.—Sample of Claims and Awards in Philadelphia's Million Dollar Cases Occurring Between July 2003–December 2004—Continued

Case Number	Verdict Date	Injury Claim	Verdict
10402642	3/10/04	Female, age 49, claimed that a neurosurgeon inappropriately recommended implantation of a device to treat multiple sclerosis and failed to obtain informed consent. Patient now a paraplegic with loss of bowel and bladder control.	$3,200,000
10601566	3/12/04	Male, age 39, with six children had abdominal complaints, but doctor did not order diagnostic tests, which would have shown gastric cancer. Cancer went from stage 1 to stage 2 requiring radiation and chemotherapy. Two-thirds of stomach removed and increased risk of recurring cancer.	$2,800,000
10902569	3/25/04	Male, age 61, died after a misdiagnosis with regard to a drug interaction between Lopid and Lipitor. Doctors improperly prescribed the medications together and failed to discontinue them when he showed signs of a debilitating muscle condition.	$1,151,028
10600854	3/25/04	Female had mammogram and doctors failed to detect cancer allowing carcinoma to advance resulting in mastectomy, reconstructive surgeries, chemotherapy, severe pain, and prospect of future medical expenses.	$2,05,000

Cases go to trial because patients and doctors disagree about whether negligence occurred or because they disagree about the values of the damages resulting from the negligent injury. The above sample of cases were ones in which the juries ruled in favor of the plaintiff. Certainly on their face the damage awards seem reasonable, given the degree of injury.

OUTLIER AWARDS TEND NOT TO WITHSTAND POST-VERDICT ADJUSTMENTS

Despite the substantial evidence indicating that juries are ordinarily conservative in deciding damages in malpractice cases, there are exceptions resulting in what are commonly labeled "outlier awards." There are a number of reasons for outlier awards that I have discussed elsewhere and I need not detail here.[39] The important point is that research evidence indicates that outlier verdicts seldom withstand post verdict proceedings.

Post-trial reductions have been documented in a number of studies.[40] I and two colleagues found that some of the largest malpractice awards in New York ultimately resulted in settlements between 5 and 10 percent of the original jury verdict.[41] A study that I conducted on medical malpractice awards in Pennsylvania[42] and a study of Texas verdicts[43] found similar reductions.

My recent research on medical malpractice verdicts in Illinois found that, on average, final payments to plaintiffs were substantially lower than the jury verdicts.[44] This does not mean that the original verdict was too high. Rather, needing money immediately and wanting to avoid a possibly lengthy appeal process, the plaintiffs settled for the health providers' insurance policy limit. Generally speaking, the larger the award, the greater the reduction in the settlement following trial.

CAPS ON PAIN AND SUFFERING

Advocates of change in the tort system claim that the jury system is broken. In addition to seeking an alternative court some have advocated for a cap of $250,000 for noneconomic damages that presumably includes not only pain and suffering, but also disfigurement and loss of society.[45]

The basic assumption for caps is that juries are too generous with their pain and suffering awards. Consequently, it is assumed that in many instances jury awards need to be reduced to some "reasonable" figure.

No one disputes the fact that caps reduce the awards to injured persons. For example, a study of California jury trials occurring between 1995 and 1999 by RAND's Institute for Civil Justice showed that California's MICRA cap of $250,000 on noneconomic damages reduced awards about 25 percent in cases involving an injury and over 51 percent in cases involving death.[46]

But questions abound regarding the fairness of caps and about their effectiveness in reducing insurance premiums.

THE FAIRNESS OF CAPS

David Studdert et al. examined the effects on injured patients of California's $250,000 cap on noneconomic damages.[47] Their findings indicate that reductions under the cap affected the patients with the most severe injuries. Those researchers concluded:

> Imposition of greater reductions on more severe injuries may be justified if compensation for this particular group of injuries were especially prone to excess. In fact available evidence suggests the reverse is true: *Plaintiffs with the most severe injuries appear to be at the highest risk for inadequate compensation*. Hence, the worst-off may suffer a kind of "double jeopardy" under caps.[48] (Italics added)

In another study, Lucinda Finley systematically examined jury verdicts in California, Florida and Maryland to determine if caps had a disparate effect on the monetary recoveries of women, and elderly persons.[49] She found that to be the case. Finley's research pointed out that cap laws tend to "place an effective ceiling on recovery for certain types of injuries disproportionately experienced by women, including sexual assault and gynecological injuries that impair child bearing or sexual functioning." In wrongful death cases women were shown to be disadvantaged in awards they would receive compared to men.

Finley separately analyzed gynecological malpractice cases involving misdiagnosed breast cancer, negligence in prenatal care that caused pregnancy loss, negligent injuries during hysterectomies, and malpractice resulting in infertility. Finley showed that over 70 percent of women's awards were for noneconomic losses. When men suffered sexual injuries during medical treatment (e.g. partial removal of a bowel and scrotum, leaving a man, age 28, impotent and infertile; a 54-year-old male treated for genital warts with undiluted ascetic acid on the scrotum and penis causing severe burns, scarring and severe pain if sexual intercourse was attempted) the pain and suffering awards were similar to those of women with roughly comparable sexual injuries. However, women are statistically far more likely to suffer such sexual injuries than men. She also pointed out that elderly people, both men and women, tend to be disadvantaged by caps. Finley also observed that because of the reduced likelihood of recovery, plaintiff lawyers are less able to take such cases because the amount that can be recovered under the caps often does not justify litigation expenses.

In 2005, the Wisconsin U.S. Supreme Court overturned that State's $350,000 cap on pain and suffering in medical malpractice cases.[50] The court reasoned that plaintiffs "*with the most severe injuries appear to be at the highest risk for inadequate compensation*" (italics added). For example, a patient suffering a severe infection for a period of months, but who eventually recovered, could receive $350,000 for pain and suffering in a jury award. In contrast, a patient who was so badly injured that she will suffer excruciating pain the rest of her life would be limited to the same amount. In the Wisconsin U.S. Supreme Court's words, "[t]he cap's greatest impact falls on the most severely injured persons."

The plaintiff in the Wisconsin case was a boy who was severely deformed at birth due to medical negligence; he can be expected to live for another 69 years. He was awarded $10,000 per year for pain and suffering. Under the cap, the U.S. Supreme Court concluded that amount would be almost halved. The Court further concluded that many cases that would be affected by caps involve children.

In summary, two systematic studies by respected researchers and the Wisconsin U.S. Supreme Court arrived at the same conclusion. Caps on pain and suffering have a disproportionate negative impact on the fairness of compensation for persons injured through medical negligence.

CONSIDERING CALIFORNIA'S MICRA CAP AND FAIRNESS

An issue of fairness also arises about California's MICRA cap of $250,000. The MICRA bill was passed in 1975. In 2005 dollars, that cap was worth $899,281. In short, the MICRA cap at the time it was passed was almost nine-tenths of a million dollars. However, during the past 3 decades the cap has never been adjusted for inflation. Thus, patients with pain and suffering awards in California have progressively lost ground due to inflation. What the California legislature decided was fair compensation in 1975 has, in real terms, been reduced by 72 percent. This insight adds to the issue of whether the cap is fair.

THE INEFFECTIVENESS OF CAPS

Research on the effectiveness of caps in reducing medical malpractice premiums lends, at best, equivocal support to the argument that they are effective.

In 2003 a U.S. Government Accounting Office (GAO) report concluded that there are no data to establish the proposition that damage caps have an effect on the number of malpractice claims, losses by medical insurers, litigation expenses, or the rates charged doctors for insurance.[51]

In the same year, Weiss Ratings, Inc., a highly respected insurance rating company, also concluded that caps do not have an effect on the physicians' insurance premiums.[52] Indeed, Weiss found that in comparison to States without caps, States with caps had greater increases in median annual insurance premiums for practices involving internal medicine, general surgery and obstetrics-gynecology.

An analysis of statistical information for 2003 by the Kaiser Family Foundation, another highly respected organization dedicated to healthcare, showed that the number of paid claims per 1,000 active physicians was unrelated to whether a State had caps on pain and suffering.[53]

Catherine Sharkey analyzed medical malpractice jury verdicts from 22 States for the years 1992, 1996 and 2001 that were collected by the National Center for State Courts.[54] Sharkey found no statistically significant relationship between the presence or absence of caps and compensatory damages in jury verdicts and trial court judgments.

I analyzed a sample of Illinois jury verdicts that provided breakdowns of the verdicts into their specific components, including pain and suffering.[55] My analysis showed that a proposed $500,000 cap on pain and suffering would functionally affect very few cases.

The Wisconsin U.S. Supreme Court decision analyzed a substantial body or empirical research bearing on caps with specific reference to the State of Wisconsin.[56] The Court drew a number of conclusions that included:

> "Based on the available evidence from nearly 10 years of experience with caps on noneconomic damages in medical malpractice cases in Wisconsin and other States, it is not reasonable to conclude that the $350,000 cap has its intended effect of reducing medical malpractice insurance premiums.
>
> The available evidence indicates that healthcare providers do not decide to practice in a particular State based on the State's cap on noneconomic damages.
>
> We agree with those courts that have determined that the correlation between caps on noneconomic damages and the reduction of medical malpractice premiums or overall healthcare costs is at best indirect, weak and remote."

In 2003, GE Medical Protective Company, the Nation's largest medical malpractice insurer, reported to the Texas Department of Insurance as follows: "Noneconomic damages are a small percentage of total losses paid. Capping noneconomic damages will show loss savings of 1.0 percent."[57]

The company also said that a provision in Texas law allowing for periodic payments of awards would provide a savings of only 1.1 percent. Medical Protective eventually raised the rates on its physician policyholders.[58]

In California in 2003, despite the cap of $250,000, GE Medical Mutual sought an increase of 29.2 percent in liability insurance premiums. Thus, the cap did not prevent insurers seeking a major increase in liability insurance rates.[59]

EXPLANATIONS FOR THE INEFFECTIVENESS OF CAPS

The rationale for caps is predicated on the following two assumptions: (1) juries are irresponsible and excessive in awarding pain and suffering; and (2) the fear of large jury awards for pain and suffering cause doctors and hospitals to settle cases for more than they are actually worth.

The first problem with the caps rationale is that it ignores the fact that most cases with large jury awards are settled for much less than the verdict, often for amounts close to the plaintiff's economic losses. Functionally, the plaintiff does not typically receive the large award for pain and suffering.

The second problem with the rationale is that it assumes that jury awards directly drive settlements. More than 90 percent of cases are settled without jury trial, with some estimates indicating that the figure is as high as 97 percent. In my study of 831 Florida malpractice cases between 1990 and 2003, more than 92 percent of claims with million-dollar payments were settled without a jury trial. Thirty-seven cases resulted in payments over $5 million. Only two of these cases were decided by a jury. Five of the 831 cases exceeded $10 million dollars, but only one was the result of a jury trial. Of the remaining four cases, one settled in pre-litigation negotiations.

A study of closed claims in Texas from 1966 through 2002 showed that plaintiff verdicts averaged only 3 percent of paid claims over $10,000.[60] In any year, jury verdicts never accounted for more than 5 percent of paid claims.

To be sure, the prospect of a jury award is possible if the case is not settled before trial, but if the case does go before a jury, data from many studies show that at trial, doctors win between 6 and 8 times out of 10. Defense lawyers and their insurers are aware of these odds because they are repeat players in the litigation process. They also know that when there is a jury award, the case frequently settles for less than the verdict amount. Research on why insurers actually settle cases indicates that the driving force in most instances is whether the insurance company and their lawyers conclude, on the basis of their own internal review, that the medical provider was negligent.[61] If they conclude negligence occurred, an attempt is made to settle; the case proceeds to trial only if the plaintiff monetary demand is unreasonable or if there is a strong disagreement over whether liability exists. Payments are typically not made in cases in which the defense concludes there is no liability.

Finally, the rationale for caps ignores problems associated with the insurance business cycle that may be responsible in whole or in part for the costs of liability insurance premiums.

CAPS AND "DEFINED PAYMENT SCHEDULES"

The fairness problems of caps as detailed above are endemic in any system that proposes "defined payment schedules" for so-called noneconomic damages.[62] My study of actual medical malpractice cases shows there is a great deal of variation among injured persons. For example, one person with a leg amputation may experience mild or no pain whereas another may experience constant excruciating "phantom pain" for the rest of his or her life.

Even when some leeway is built into compensation schedules, they cannot take into account the number of factors and extreme variability of pain and suffering, physical impairment, mental anguish, loss of society and companionship, and other elements of damages that fall under the rubric of noneconomic damages. That is why these matters have been entrusted to juries. They provide justice on an individualized basis.

Moreover, there is another form of fairness problem that involves types of claims. A person injured in an automobile accident will have a full right to have his or her damages decided by a jury. A person with exactly equal injuries resulting from medical negligence will not have this right. What possible rationale can be given for treating medical patients differently?

TOO MUCH EMPHASIS ON JURIES! MOST CASES SETTLE BEFORE TRIAL

In testimony before the Illinois General Assembly in 2005, Lawrence Smarr, President of The Physician Insurers Association of America presented data indicating that jury verdicts for plaintiffs constituted only about 3 percent of medical malpractice payments.[63]

In recent research, I and my colleagues have been studying closed medical malpractice claims in the State of Florida.[64] Florida has required medical liability insurers to file detailed reports of closed medical malpractice claims with the Department of Health since 1975. In this research we centered on cases closed between 1990 and 2003. A total of 21,809 claims were closed with a payment to the claimant during those 14 years. We found that 20.2 percent of paid claims were settled without the claimant even resorting to a lawsuit, 6.3 percent of claims were settled in arbitration and 70.8 percent settled before a jury verdict, leaving just 2.7 percent of paid claims that resulted from a jury verdict.[65]

To pursue this insight further we singled out cases involving a million dollars or more.[66] We found that 10.5 percent were settled without a lawsuit and 4.6 percent were settled in arbitration, 77.4 percent were settled before or during trial and only 7.6 percent resulted from a jury verdict. Put in the obverse, more than 92 percent of claims with million dollar payments were settled without a jury. Going further, we found that 37 of the 831 million dollar cases resulted in payments over $5 million. Only two of these cases were settled following a jury trial. Five of the 831 cases exceeded $10 million dollars but only one was the result of a jury trial; of the remaining four cases one was settled in pre-litigation negotiations, and three settled before a trial had commenced.

Perhaps Florida is different than other States. It is hazardous to generalize because each State has its own unique set of laws and legal culture. Nevertheless, it is interesting to observe that data from North Carolina seems roughly consistent with the Florida findings. I compared Carolina data on verdicts and settlements.[67] The data tended to show some interesting patterns. As early as the first part of the 1990s decade there were verdicts and settlements exceeding $1 million. Over the period from 1990 through 2002, the number of million-dollar-plus settlements exceeded the number of million-dollar-plus jury verdicts by a factor of over 3 to 1. The

average amounts of $1 million-plus settlements were comparable to the jury awards. A statistical test on the data indicated that the distributions and the magnitudes of payments for jury verdicts and non-jury settlements were not statistically different from one another. In short, the North Carolina findings also indicated that most of the payments exceeding a million dollars involved settlements rather than jury trial.

These findings have a major implication. Whether we are talking all cases or just million dollar cases the process by which claims are paid in Florida (and, it appears, also in North Carolina) involves the negotiation table, not the jury room. In Florida settlements exceed jury trials by a factor of more than 9 to 1 for million dollar cases.

A LOOK AT FLORIDA MILLION DOLLAR SETTLEMENTS WITHOUT LAWSUITS

Our Florida research on million dollar cases allow further insights into the losses incurred in medical negligence cases. Recall again, that in these cases the health providers did not contest liability, and settled to avoid the expenses of a lawsuit they were almost sure to lose. Through 1998, the Florida closed claim files contained information on "structured settlements." The details of these cases provide insights about the nature of the injury, the long-term costs and about the collateral losses such as children left without the services of a parent.[68]

Table 2.—Year, Case Name, Injury and Details of Settlement

Settle Year	Case	Sex	Age	Injury	Settlement	Structured
1991	BMH	M	0	Spastic quad; cerebral palsyriplegia.	$1,887,044	$1 million cash plus $887,044 annuity yielding an expected total payment to child of $13,855,826.
1992	WCD	M	1	Sever brain damage, blind, deaf, immobile.	$1,000,000	$640,000 cash plus $540,000 annuity yielding $2,557/month for child plaintiff.
1992	UMS	F	0	Severe mental, emotional impairment.	$3,000,000	No details except as estimate that the annuity would yield $5,914,774.
1993	CRH	F	2	Severe cerebral palsy secondary to hypoxia.	$6,000,000	$4,922,115 cash; plus $1,077,885 present value for structured trust expected to yield $3,179,273 (Note medical expenses incurred to date of the settlement = $989,164).
1993	TGP	M	43	Renal cell carcimona.	$2,000,000	$1,389,542 cash plus $610,459 for structured settlement for 3 surviving minor children.
1993	AHP	F	0	Paraplegia	$3,750,000	$2,300,000 plus $1,450,000 present value for annuity.
1994	AR	M	0	Profound brain damage.	$1,000,000	$440,178 cash plus $559,822 annuity yielding a total of $2,912,000.
1994	GBP	F	39	Vegetative state, non-reversible.	$3,000,000	$1,500,000 cash plus $1,500,000 annuity expected to yield an expected payment to the plaintiff of $8,783,183 for plaintiff and four minor dependants.
1995	FHH	M	25	Spinal cord injury	$2,647,617	$1,156,000 cash plus $1,491,000 for structured annuity expected to yield $5,291,937.
1995	CHM	M	0	Canavan's Disease (degenerative disorder of central nervous system).	$2,383,900	$1,092,209 cash plus $1,291,691 for annuity yielding lump sum payments at 5 and 10 years totalling $2,000,000.
1995	HBM	F	32	Coma	$7,250,000	Cash and annuity cost unknown but annuity estimated to yield $16,129,528.
1996	RLC	UK	UK	Death	$1,500,000	$1,429,808 cash plus $70,192 for annuity yielding a total payment to plaintiff's family of $1,422,239.
1996	CPC	M	0	Required resuscitation; neurological damage.	$2,500,000	$1,187,940 cash plus $1,312,060 for annuity, yielding $3,307,824 for the child.

Table 2.—Year, Case Name, Injury and Details of Settlement—Continued

Settle Year	Case	Sex	Age	Injury	Settlement	Structured
1996	ORH	F	0	Brain damage	$7,300,000	$5,100,000 cash plus paid on behalf of four defendants plus $2,200,000 for an annuity. Total yield of annuity unknown.
1996	GMI	F	0	Severe brain damage.	$6,379,322	$5,529,332 cash plus $850,000 annuity yielding $8,066/mo for life of the child.
1996	DCH	M	0	Cerebral palsy	$3,000,000	$2,600,000 cash plus $800,000 annuity expected to yield $13,783,483 over the child's life.
1996	CKR	F	30	Brain herniation	$3,000,000	$1,800,000 cash plus $1,200,000 from three insurance carriers for an annuity expected to yield a total of $7,816,824.
1996	FHA	M	0	Cerebral vasculitis and bilateral thalamic infarcts.	$6,500,000	$4,500,359 cash plus $1,999,641 for an annuity yielding $7,855/mo for life plus periodic cash payments graduating from $50,000/yr to balloon at $25 years to $250,000.
1997	SVC	M	52	Brain damage	1,000,000	$582,935 cash plus $417,065 for annuity, yielding expected total of $1,572,935.
1997	HCP	M	49	Death	$5,000,000	$4,000,000 cash plus $1,000,000 annuity yielding projected $3,976,503 for decedent's minor daughter.
1997	KCM	F	37	Paraplegia and cauda equina syndrome (spinal cord ends).	$3,520,160	$1,845,160 cash plus $1,675,000 to two annuity companies yielding an expected total of $8,157,597.
1998	GJL	F	52	Paraplegia	$1,000,000	$500,000 cash plus $500,000 annuity starting at $2,500 per month and then adjusted for inflation.
1998	COR	M	56	Death	$1,000,000	Payout of approximately $2,000 per month over 35 years.
1997	LMG	M	39	Death	$1,250,000	$553,359.60 cash plus annuities purchased at $354,456, $11,048.20 and $111,048.20 yielding a total of $1,129,912.
1998	UM	F	56	Right ankle, left below knee amputation.	$1,625,000	$700,000 cash annuity providing $4,000 per month for 5 years and $1,000 per month for 7 years.
1998	GSHI	M	62	Quadriparesis, neurogenic bladder.	$1,449,032	$675,000 cash and annuity providing $9,750 per month for 5 years or life.
1998	UCH	M	2	Profound brain damage.	$5,000,000	$2,500 per month, increase 3 percent per year. 20 years guaranteed, plus life.
1997	CKMC	F	37	Paraplegia and cauda equina syndrome (spinal cord ends).	$3,520,000	Cash payments of $1,845,160 and two annuities purchased with present value of $1,675,000: total payments estimated at $8,157,597.
1999	SPGH	F	0	Severe cognitive delays, requires occupational therapy, physical therapy, speech therapy.	$5,500,000	Total annuities yielding $12,754.31 per month.
1999	PRMC	F	21	Death	$2,250,000	Cash of $1,809,709 plus annuity for surviving child purchased at $440,291.
1999	PRMC	F	1	Hemorrhagic periventricular leukomalacia, hypoxic ischemic injury resulting in motor development delay, cognitive defects.	$3,300,000	Cash of $907,829 plus annuity purchased for $2,392,171 for life care of child.

In some instances the estimated payments were staggering, reflecting medical costs to the patient, income losses, and/or financial support for surviving minor children. Case BMH (1991) was estimated at over $13 million; Case GBP (1994) was estimated at almost $9 million; case DCH (1996) was estimated at almost $14 million. In case CKR (1996), which the insurer rated only a 7 in level of injury seriousness, the estimated cost was almost $8 million, suggesting that the medical injury was more serious than reported, that the claimant had a large income loss or a combination of both of these factors. Case HBM (1995) was estimated at over $16 million; and Case KCM (1997) was estimated at over $8 million.

There is one additional matter to consider about these data. We compared these nonlawsuit settlements with the final settlements of cases that were settled following a jury verdict. The verdict settlements were comparable to the cases in which negligence was conceded. These data provide further confirmation that the ultimate outcome of jury verdicts tends to reflect actual losses incurred by severely injured patients.

THE SHADOW EFFECT OF JURY TRIALS IS MISLEADING

Was it a fear of large jury awards—the "shadow effect"—that caused defendants to settle? Alternatively, was the negligence and severity of loss so clear in most of the cases that it made no sense to go to trial because defendants' liability insurers would incur heavy litigation costs in the face of a likely win for the patient? Without question the threat of a jury trial is what forces parties to settle cases. The presence of the jury as an ultimate arbiter provides the incentive to settle but the effects are more subtle than just negotiating around a figure. The threat causes defense lawyers and the liability insurers to focus on the acts that led to the claims of negligence.

Research by Peeples et al. on a sample of insurers' medical malpractice files indicated that insurers tend to settle cases primarily based on whether their own internal reviews by medical experts indicate the provider violated the standard of care.[69] If they decide the standard has been violated they attempt to settle. Those authors concluded that claims proceed to trial only when the plaintiff cannot be convinced that there was no violation of the standard and cannot extract a reasonable offer from the insurer. An earlier study by Rosenblatt and Hurst examined 54 obstetric malpractice claims for negligence.[70] For cases in which settlement payments were made there was general consensus among insurance company staff, medical experts and defense attorneys that some lapse in the standard of care had occurred. No payments were made in the cases in which these various reviewers decided there was no lapse in the standard of care.

I used some of the same closed claim files from medical insurers in my book, *Medical Malpractice and the American Jury*. I reached a similar conclusion.

At the very least the findings strongly suggest that all of the emphasis on jury verdicts appears misplaced.

RISING CLAIMS AND RISING COSTS: A COMPLICATED ISSUE

The Florida data also allow us to address the question of whether the frequency of malpractice claims have been rising and whether simultaneously so have the costs of payouts. We found that the number of claims involving payments to the claimant had increased between 1990 and 2003. However, Florida's population also increased at the same time as did the number of licensed physicians. When we adjusted for population growth, the number of paid claims per 100,000 residents in 2003 was no higher than in 1990. Similarly, we found the paid claims per 100 licensed physicians also were no higher. This would seem to support consumer groups who say there has been no increase.

Doctors and insurers say that the number of claims began to rise steeply around the year 2000 and continued through 2003. Claims with no payment also incur transaction costs to defend. It is noteworthy, that data collected by the National Center for State Courts on a national sample of cases showed that while there was an overall decline in medical malpractice case filings between 1992 and 2001, filings did rise in 2002.[71]

Our Florida closed claims data also revealed that between 1990 and 2003 the inflation adjusted cost of the average paid claim showed a modest upward increase over the 14-year period. Part of the explanation might be that medical costs, which have increased at rates greater than the Consumer Price Index, are the cause. But there are other explanations. Our data also showed that on average the paid claims, beginning in 2002, included a greater proportion of serious injuries, including death.

FRIVOLOUS LITIGATION

Claims about frivolous litigation are based, in part, on findings that in medical malpractice cases doctors prevail in approximately 70 percent of cases that go to trial and that as many as 50 percent of cases filed against healthcare providers ultimately result in no payment to the plaintiff.[72] Additionally, opponents of medical malpractice litigation argue that jury verdicts, especially those involving larger awards, encourage lawyers to file lawsuits in cases that are not meritorious because doctors and liability insurers will settle claims, not out of merit, but rather out of fear of a large and unjustified award if the case goes before a jury.[73] These claims are not supported by research evidence.

LIABILITY INSURERS TEND TO NOT SETTLE FRIVOLOUS CASES

In interviews with liability insurers that I undertook in North Carolina and other States, the most consistent theme from them was: "We do not settle frivolous cases!"[74] The insurers indicated that there are minor exceptions, but their policy on frivolous cases was based on the belief that if they ever begin to settle cases just to make them go away, their credibility will be destroyed and this will encourage more litigation.

CASES DROPPED BY CLAIMANTS BEFORE TRIAL ARE NOT NECESSARILY FRIVOLOUS

In *Medical Malpractice and the American Jury*,[75] I reported that despite up-front screening by plaintiff lawyers, there is still a lot of uncertainty about whether negligence has occurred. This can usually only be determined after a lawsuit is filed, depositions are taken and expert opinions are obtained. As documented in that book, research into the files of liability insurers showed that this is as true of the defense side as it is of the plaintiff side: lawyers for the defendants and their insurers get conflicting opinions as to whether negligence has occurred. Sometimes, after an extensive process of consulting with experts and the taking of depositions, it becomes reasonably apparent that no legal negligence has occurred, or that, in any event, the case is "not winnable" because of the costs that would be entailed in pursuing it. At this juncture plaintiff lawyers tend to drop the case. In North Carolina nearly 40 percent of filed cases were dropped on these grounds. Again, the point to be made is that it makes little economic sense for a plaintiff lawyer to continue to invest time and money in a case that he or she is unlikely to win. It is true that occasionally lawyers misjudge the merits of cases and continue to pursue them, but far more often they are dropped.

Thus, given the fact that both plaintiff and defendant are faced with uncertainty, it is inappropriate to call the vast majority of dropped cases "frivolous." Rather, they should be labeled "nonmeritorious" cases in recognition of the fact that both sides took them very seriously at the beginning of the lawsuit.

DOCTOR'S HIGH "WIN RATES" AT TRIAL DO NOT MEAN THE LAWSUIT WAS FRIVOLOUS

As I discussed earlier, statistics indicate that, nationwide, doctors prevail in about 70 percent of cases that go to trial.

Nevertheless, a plaintiff loss at trial is not grounds for concluding that the litigation was "frivolous."[76] Cases that go to trial are ones where negligence is uncertain. As discussed above, when pretrial investigation shows that the case is clearly not winnable, lawsuits tend to be dropped before trial. On the other hand cases with clear negligence tend to be settled, particularly if the parties can negotiate the amount of damages. Thus, only "close cases" tend to go to trial.

There are a number of possible explanations, other than nonmerit, as to why doctor win rates at trial are so high.[77] One reason is that jurors generally tend to be skeptical of plaintiff claims and essentially place a burden on the plaintiff that is greater than the legally appropriate "balance of probabilities" standard. Another is that plaintiffs often have a more difficult time obtaining and hiring the experts, relative to the defense. It is also important to observe that my research showed that in many instances, plaintiffs who lost at trial against one doctor nevertheless obtained settlements from other doctors who had been named in the lawsuit.[78] This might suggest that medical negligence had occurred in the case, albeit at trial the jury did not think that the evidence against the remaining defendant or defendants was sufficient to find liability. On the other hand it is certainly possible that despite insurers' insistence that they do not make settlements for nonmeritorious claims, in some instances they may decide that a modest and confidential settlement payment avoids bad publicity for the doctor and saves expensive litigation costs. Such decisions could explain why some doctors settle.[79]

CLAIMS ABOUT INCREASING LITIGATION COSTS

Insurers have made claims about increasing litigation costs and blamed them on frivolous litigation.[80] However, there are two studies that have provided data on these transaction costs.

The Florida closed claim files that we examined in our research also contained insurers' reports on their litigation expenses.[81] The data on no-payment claims were reliable only for the years 1990 through 1997. The mean, or average, litigation expense, adjusted to 2003 dollars, was $22,205 per claim. It is again important to reemphasize my findings that nonpaid claims should not necessarily be characterized as frivolous. Many unfounded claims begin as credible claims in both the eyes of the plaintiff and the defendant. It is only after sometimes lengthy periods of depositions of experts and other investigation that the evidence indicates that it is unlikely that negligence occurred. To be sure these are unfortunate transaction costs to insurers—as well as plaintiff lawyers.

Our research also examined insurers' litigation costs for pain claims over a 14-year period covering 1990 through 2003. The litigation costs for these claims in the years 2000 through 2003, when adjusted for inflation were not statistically greater than a comparable period a decade earlier (1990–1993).

Research by Bernard Black and his co-authors on closed claim files from Texas showed that one defense costs per each large claim that was paid rose steadily from 1988 through 2002.[82] The ratio of defense costs relative to payout increased from about 8 percent to about 15 percent. However, the data showed that defense costs rose gradually, and the absolute size of these costs remain[ed] small relative to payouts."[83]

Litigation costs may vary from State to State depending on a number of factors. Nevertheless two independent studies using data supplied by insurers to the States of Florida and Texas do not support extreme claims of rising litigation costs.

"JUDICIAL HELLHOLES:" THE DOCTOR EXODUS CLAIM

The American Medical Association has identified a number of "crisis States" in which it is alleged that because of the "abusive litigation" climate doctors were leaving certain areas or certain States.[84] One of those areas involved Madison and St. Clare counties in Illinois.[85] Indeed President Bush traveled to those counties in January 2005 after being informed that these were two counties in deep trouble because of medical malpractice litigation. Reports of the number of doctors leaving those counties as reported in the *Wall Street Journal* and other sources ranged as high as 180 doctors. That figure would amount to more than 26 percent of the total doctors in those counties. I checked those claims by using official American Medical Association statistics reported in its annual publications of *Physician Statistics and Distribution in the U.S.*

I considered only doctors described as "treating non-Federal physicians," thus centering only on the doctors whose liability insurance rates would be affected by the alleged crisis. Contrary to the wild assertions, these statistics showed a steady increase in the number of doctors in the combined from 1994 through 2003. In comparison to 2000 the number of physicians increased by 4 percent in 2003.

Similar claims were made for the whole State of Illinois particularly with respect to Cook and Du Page counties.[86] When I checked the AMA statistics I again found steady increases in the number of doctors, both in absolute numbers and in relation to Illinois' population growth. Because obstetrician-gynecologists and neurosurgeons are alleged to be two groups most affected in the alleged exodus, I found that their numbers, relative to Illinois' population had remained relatively steady since 1994.

Pennsylvania is another State alleged to be experiencing a doctor exodus.[87] A media release by the Pennsylvania Medical Society claimed that a survey:

> ". . . discovered one in four Pennsylvanians lost their doctors due to the rising costs of liability insurance. According to the poll, 26 percent said they saw their doctors move, give up certain procedures, or stop practicing medicine as liability insurance costs skyrocketed."

Once again I went to the official American Medical Association statistics. Similar to Illinois I found that the number of patient care physicians increased at an average annual rate of about 1 percent per year in proportion to the population. The number of obstetricians declined slightly, but so had Pennsylvania's birth rates, strongly suggesting that the drop may have been a result of fewer needs for this medical specialty. There was a slight decline in the number of neurosurgeons but Pennsylvania still had more neurosurgeons per capita than the rest of the Nation.

In short the doctor exodus claims received no support in studies of the American Medical Associations' own statistics.

HEALTH CARE COURTS: BE CAREFUL FOR WHAT YOU WISH FOR!

Finally, I wish to offer a brief commentary on the proposed Special Health Care Courts. Consumer Interest groups, such as the Center for Justice and Democracy, have raised serious criticism about such health courts.[88] They argue that the proposed courts deprive citizens of the constitutional right to jury trial because they provide no right to appeal the court's decision. They also argue that the probable schedule of payments to injured persons is likely to ignore the unique circumstances of losses of claimants. They further argue that the courts, the experts likely to be appointed by the courts and the amounts of payments under the schedules are likely to not consider the factual circumstances. Additionally, they identify the danger that those courts, as proposed, are very likely to be subject to many political pressures that could affect the rights of persons injured through medical negligence. I agree with those criticisms!

However, I wish to add an additional problem. The Health Court proposal assumes that cases can be handled more efficiently than the current tort system. To be sure there are inefficiencies in the tort system. However, those inefficiencies have to be weighed against inefficiencies that will be endemic to health courts as well. As I have pointed out in my discussion of so-called frivolous litigation in my testimony today and in my book, *Medical Malpractice and the American Jury*, medical malpractice cases involve complex issues that can only be sorted out after considerable investigation and discovery. When patients make claims of negligence the process of discovering whether negligence occurred requires investigating medical records, interviewing the involved parties (through sworn depositions), fording experts, sorting out conflicts between the opinions of experts, reinvestigating the records and testimony as new insights are uncovered and then reaching some kind of consensus, if possible, about what actually occurred and whether those facts meet the definition of legal negligence. This process takes considerable time as well as money. For complex cases the process of finding competent experts and getting them to review cases under their busy, over-booked schedules means that cases cannot be resolved in weeks, indeed even in months. Sometimes it takes years. Any competent defense or plaintiff lawyer who works in this area will confirm my assertions. To be fair to both sides, health courts will have to do the same thing. Health courts will also have to bear these transaction costs.

As I have pointed out in my testimony today, under the current tort system many of these investigative costs are borne now by plaintiff lawyers. They screen cases and eliminate many cases before legal claims are made. Under a Health Court System, if those claims are to be fairly adjudicated, most of the costs will be borne by the health courts and the American taxpayers who underwrite the costs of those courts.

CONCLUSION

I will not reiterate the many points I have made in my testimony. The bottom line is that most of the claims made about juries and the tort system do not stand up to empirical scrutiny.

Finally, I want to close with a statement that I am strongly in favor of measures that improve the quality of healthcare. I am strongly in favor of voluntary measures such as the Medical Error Disclosure Program at the University of Michigan. Such programs should be voluntary on the part of patients and they should retain the right to trial by jury.

ENDNOTES

1. David M. Studdert et al., *Claims Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 New England Journal of Medicine 2024 (May 11, 2006).

2. *Id.* at 2031.

3. *See, e.g.* Thomas Baker, The Medical Malpractice Myth (2005) for an outstanding review of the literature.

4. *See, e.g.,* http://cgood.org/healthcare.html; http://www.hsph.harvard.edu/press/releases/press001102005A.html.html.

5. Hillary Clinton and Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, 354 New England Journal of Medicine 2205 (2006).

6. Harvard Medical Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation and Patient Compensation in New York (1990). *See also* Paul C. Weiler et al., A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation (1993).

7. *Id.* at 44, Table 3.2.

8. Eric J. Thomas et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, 38 Medical Care 261, 261 (2000).

9. Lori Andrews, *Studying Medical Error in SITU: Implications for Malpractice Law and Policy*, 54 DePaul Law Review 357 (2005).

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16. *See generally*, Ill. Pattern Jury Instr.-Civ. 30.04.03 (2005 ed.); Ill. Pattern Jury Instr.-Civ. 34.02 (2005 ed.); West's Smith-Hurd Illinois Compiled Statutes Annotated and cases cited in the annotations. Chapter 740. Civil Liabilities, Act 180. Wrongful Death Act, 180/1. Action for damages.

17. Neil Vidmar et al., *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DePaul Law Review 315 (2005).

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29. Harry Kalven, Jr. and Hans Zeisel, The American Jury (1966); Larry Heuer and Steven Penrod, *Trial Complexity: A Field Investigation of Its Meaning and Its Effects*, 18 Law & Hum. Behavior 29 (1994).

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31. *See* Neil Vidmar, *Are Juries Competent to Decide Liability in Tort Cases Involving Scientific/Medical Issues? Some Data from Medical Malpractice*, 43 Emory L.J. 885, 885–91 (1994).

32. Neil Vidmar and Shari Seidman Diamond, *Juries and Expert Evidence*, 66 Brooklyn Law Review 1123 (2001); Sanja Kutnjak Ivković and Valerie P. Hans, *Jurors' Evaluations of Expert Testimony: Judging the Messenger and the Message*, 28 Law & Soc. Inquiry 441 (2003).

33. Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering"*, 83 Northwestern University Law Review 908 (1989).

34. Neil Vidmar et al., *Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards*, 48 DePaul L. Rev. 265, 287 (1998).

35. Thomas H. Cohen, *Civil Justice Survey of State Courts, 2001: Tort Trials and Verdicts in Large Counties, 2001 Bureau of Justice Statistics, No. NCJ 206240,* (2004).

36. Neil Vidmar et al. *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DePaul Law Review 315 (2005).

37. Charles Black, et al., *The Myth of the Medical Malpractice Claims Crisis*, 2 Journal of Empirical Legal Studies 207 (2005).

38. *See* Catherine Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps*, 80 New York University Law Review 391 (2005).

39. *See* Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, The Contingency Fee System, Juries and Social Policy*, 38 Loyola of Los Angeles Law Review 1217 (2005). There are four processes by which awards are reduced. The judge reduces the award verdict through remittitur. An appeals court reduces the award. Sometimes the sides agree that there was negligence, but disagree about the amount of damages and set a high-low agreement prior to trial or during trial: they agree that if the jury verdict is above a certain limit, the plaintiff will only get the high limit and if it is below the bottom limit or even if the defendant prevails at trial, the plaintiff will receive the minimum payment. Most common of all, the plaintiff and the defendant negotiate a post-trial settlement that is less than the jury verdict, often for the amount of the doctor's liability coverage.

40. Earlier studies involving nonmedical malpractice as well as malpractice verdicts include: Ivy E. Broder, *Characteristics of Million Dollar Awards: Jury Verdicts and Final Disbursements*, 11 Justice System Journal 349 (1986); Michael G. Shanley and Mark A. Peterson, RAND: The Institute for Civil Justice, Post-Trial Adjustments to Jury Awards (1987); Brian Ostrom et al., *So the Verdict Is In—What Happens Next?: The Continuing Story of Tort Awards in the State Courts*, 16 Just. Sys. J. 97 (1993); Deborah Jones Merritt and Kathryn Ann Barry, Is the *Tort System in Crisis? New Empirical Evidence*, 60 Ohio St. Law Journal. 315, 353–55 (1999).

41. Neil Vidmar, Felicia Gross and Mary Rose, *Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards*, 48 DePaul Law Review 265 (1998).

42. Neil Vidmar, Medical Malpractice Litigation in Pennsylvania. Report Commissioned and Funded by the Pennsylvania Bar Association, May 2006.

43. David Hyman and Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives Stupid*, Vanderbilt Law Review (in press, 2006).

44. Neil Vidmar and Kara MacKillop, *"Judicial Hellholes:" Medical Malpractice Claims, Verdicts and the "Doctor Exodus" in Illinois*, Vanderbilt Law Review (in press, 2006).

45. *See* Howard Richter, Statement of the Pennsylvania Medical Society Liability Insurance Company before the Pennsylvania Senate Banking and Insurance Commission Regarding the Medical Malpractice Market in Pennsylvania, March 26, 2003; David Wenner, *Lawsuits Illuminate Debate over Malpractice!,* The Patriot News, April 10, 2005.

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47. David Studdert, Tony Yang, and Michelle Mello, *Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California*, 21 Health Affairs 54 (2004).

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49. Lucinda Finley, *The Hidden Victims of Tort Reform: Women, Children and the Elderly*, 53 Emory Law Journal 1263 (2004).

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51. U.S. General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836 (August 2003).

52. Martin D. Weiss et al., *Medical Malpractice Caps: The Impact of Noneconomic Damage Caps on Physician Premiums, Claims Payout Levels and Availability of Coverage*, Weiss Ratings, Inc. (2003), available at http://www.weissratings.com/malpractice.asp.

53. The Kaiser data for individual States can be found at http://www.state healthfacts.org/r/malpractice.cfm.

54. Catherine Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps*, 80 New York University Law Review 391 (2005).

55. Neil Vidmar, *Medical Malpractice and the Tort System in Illinois, A Report to the Illinois State Bar Association*, May 2005 available at http://www.isba.org/medmal05.html

56. *Ferdon* v. *Wisconsin Patient Compensation Fund et al.,*, Case 2003 AP 988 (2005 WI 125), at paragraphs 129, 166 and 175.

57. *See* http://www.consumerwatchdog.org/insurance/rp/rp004689.pdf.

58. The Nation, October 26, 2004.

59. *Id.*

60. Bernard Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988–2002* 2 Journal of Empirical Legal Studies 207 (2005).

61. Ralph Peeples et al., *The Process of Managing Medical Malpractice Cases: The Role of Standard of Care*, 37 Wake Forest L. Rev. 877 (2002); R.A. Rosenblatt & A. Hurst, *An Analysis of Closed Obstetric Malpractice Claims*, 74 Obstetrics & Gynecology 710 (1989); *See* also Neil Vidmar, Medical Malpractice and the American Jury (1995), at Chapter 8, page 83.

62. *E.g.* http://www.theorator.com/bills109/s1337.html.

63. Lawrence E. Smarr, Testimony before the Illinois General Assembly, House Judiciary—Civil Law Committee Hearing, April 7, 2005 at http://www.ihatoday.org/issues/liability/talk/smarrtest.pdf This interpretation of Smarr's data is taken from Exhibit B of his testimony. The exhibit shows that paid claims constituted 25.2 percent of all claims and that plaintiff verdicts constituted .8 percent of this total.

64. Neil Vidmar et al., *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DePaul Law Review 315 (2005).

65. Trial rates for medical malpractice cases usually range between 7 and 10 percent of lawsuits. These include cases in which defendants prevail, approximately 7 or 8 trials in 10, see Vidmar, supra note 2 at 39. The data reported here do not include plaintiff verdicts at trial but they do include cases that never became lawsuits. In short our data are using a different numerator and different denominator than previous studies.

66. The payments were adjusted for inflation so that we could compare earlier cases with later cases.

67. Testimony of Neil Vidmar before the North Carolina House Blue Ribbon Task Force on Medical Malpractice, Raleigh, NC, January 7, 2004. The same data have been used by the North Carolina Trial Lawyers Association and by Medical Mutual of North Carolina, a doctor-owned liability insurer.

68. *See* Neil Vidmar, Kara MacKillop and Paul Lee, *Million Dollar Medical Malpractice Cases in Florida: Post-verdict and Pre-suit Settlements*, Vanderbilt Law Review (in press, 2006).

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70. Rosenblatt and Hurst, *An Analysis of Closed Obstetric Malpractice Claims*, 74 Obstetrics and Gynecology 710 (1989).

71. National Center for State Courts, Examining the Work of State Courts, 2002: A National Perspective from the Courts Statistics Project 25 (2002), available at <http://www.ncsonline.org>.

72. *See* Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, The Contingency Fee System, Juries and Social Policy, 38 Loyola of Los Angeles Law Review 1217 (2005).*

73. *See, e.g.* http://www.sickoflawsuits.org.

74. *See* Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, The Contingency Fee System, Juries and Social Policy*, 38 Loyola of Los Angeles Law Review 1217 (2005); Neil Vidmar, Medical Malpractice and the American Jury (1995).

75. *Id.* Frank Sloan et al., Suing for Medical Malpractice (1993) at 164–185 reports systematic data that are consistent with my conclusions.

76. *See* Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, The Contingency Fee System, Juries and Social Policy*, 38 Loyola of Los Angeles Law Review 1217 (2005); Neil Vidmar, Medical Malpractice and the American Jury (1995).

77. *Id.*

78. *Id.* at 33–34.
79. Many doctors want to avoid the publicity, the emotional pressures and the time from her practice that a trial would entail. However, in other cases the doctor may insist on going to trial to clear her reputation, *Id*.
80. *See* Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, The Contingency Fee System, Juries and Social Policy*, 38 Loyola of Los Angeles Law Review 1217 (2005); Neil Vidmar, Medical Malpractice and the American Jury (1995).
81. Neil Vidmar et al., *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DePaul Law Review 315 (2005) at 350–352.
82. Bernard Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1998–2002* 2 Journal of Empirical Studies 207 (2005).
83. *Id.* at 252.
84. *See* AMA website at http://www.ama-assn.org/ama/pub/category/7861.html.
85. *See* Neil Vidmar and Kara MacKillop," *Judicial Hellholes;" Medical Malpractice Claims, Verdicts and the "Doctor Exodus" in Illinois*. Vanderbilt Law Review (in press, 2006)
86. *Id.*
87. *See* Neil Vidmar, Medical Malpractice Litigation in Pennsylvania: A Report Commissioned and Funded by the Pennsylvania Bar Association, May 2006.
88. Center for Justice and Democracy, *Why Health Courts are Unconstitutional*, Pace Law Review (in press).

The CHAIRMAN. I am about 20 minutes late for voting. I may not get this vote in, but I did want to hear all of the testimony. I'll be back to ask some questions. I know that we have imposed on your time. Any of you who wish to stay, I think perhaps Senator Clinton and Senator Kennedy wanted to ask some questions, too. If you need to leave, we'll submit some questions in writing, even if you stay, we'll probably do the same, because there are some that are fairly technical questions that we usually want to have as part of the record.

So, thank you for your testimony, and I will be back.

[Recess.]

The CHAIRMAN. Well, I see we didn't lose anybody from the panel. I really appreciate your tolerance of the time that it takes for us to vote. There were three different votes, and I did make it back in time for the first one. They held it open a few extra minutes so I could do that, but I appreciated getting all the testimony in one block. It's a tremendous amount to digest. I appreciate the submitted comments, which I have looked over, and that's been very helpful.

I do have a few questions that I'll ask here and then we'll submit others in order to obtain more detailed answers as we get into the real heart of the issues. I also had a great conversation with Senator Clinton on the floor, who will probably be submitting some questions as well. She has a statement regarding a bill she's been working on that probably could have some incorporation into the base bill that we're talking about.

We are actually looking for solutions. We want to find some way that people can be compensated fairly, hopefully compensated more quickly, and hopefully, more of the compensation will go to the person who has actually been harmed or to the family of that person. And for that, Ms. Sheridan, I particularly want to thank you for your testimony. You know, there's a city in Wyoming that's probably named after your family. That's where I graduated from high school.

But you've been through this process. You've seen it from a position that many of us have not. And so, what I would ask, is that,

as we move through this process, you would help us to evaluate and to see from your standpoint whether you think we're touching on something that would have helped in your situations and others that you know of.

You've heard the testimony today. I don't know if there's any of it that you'd particularly like to comment on at this point, but I would ask for your help as a reviewer of what we're doing.

Ms. SHERIDAN. Well, I think that something—I mean, I like all of the ideas, and of course, I don't have the answer. But I think something that would help me is when people say that certain interventions have been successful. For example, I think it was—Richard, did you mention Texas, that they were able to bring back physicians into Texas. Was that because of the caps or—who mentioned that? Oh, it was the Senator; that's right.

And so, my question is: Is that really a successful program? Do we measure success by retaining doctors in States, or do we measure success by talking to patients who have really been harmed? And so, when people talk about successful interventions that have come to the tort system, we need to evaluate both sides of the coin and not just by, have we reduced the number of lawsuits by saying we're sorry or by the numbers paid out. Have we asked the patients are they satisfied with this? And this usually gets eliminated and not done when we look at some of these interventions. So as we talk about successful strategies, that is the one point that I would like to clarify is how do we define successful or success when we're looking at other interventions?

You know, whether or not we keep the court system as it is but refine it is another question. Do we completely abandon the court system as, you know, and do health courts? That's another good question. But as I mentioned, I think that other people agree, that the way the tort system currently exists, it has lost its integrity and honor. And can we bring that back into the current system? I don't know, but it will take a lot of very bold policymakers to implement changes with regard to gag clauses, especially expert witness testimony oversight, and other tools that are incredible strategic mechanisms that are used in the tort system.

The CHAIRMAN. I thank you for that. You've certainly hit on a real key there: What is success? I would mention that the bill that I've drafted is a demonstration project which would allow a number of different mechanisms to be tried on a limited basis to see if they work before imposing them on the whole Nation. And, we'll be interested in your evaluation of success on that as well. Thank you.

Mr. Studdert, in your testimony, did your data indicate that there were any particular issues; that injuries with particular problems—for instance, did juries have lower accuracy in dealing with, maybe, obstetrics as opposed to dermatology or other fields of medicine? Did you see that more complex cases were most often misinterpreted by a jury versus the straightforward cases, or did it get into that level of——

Mr. STUDDERT. Well, we did to some extent. We have a follow-up analysis which will be published probably later in the year that tries to look more closely at the claims that were resolved we think wrongly; that is, either errors that were not paid or claims that

didn't involve errors that were paid; those two types of discordant outcomes.

I should stress that only about 10 percent of the cases we looked at actually went to trial, so there were wrongly decided cases in both settings. But our preliminary findings in this area are quite interesting. So, on the question of which types of claims involved error but didn't get paid, we look at a number of different predictors on that, and interestingly, one of the predictors is decision before a jury. And I think it comes back—so it was more likely that a claim that involved error would be decided against the plaintiff inside a courtroom than outside a courtroom.

And I think it goes back to the earlier point I was making: this doesn't suggest that juries are consistently doing a bad job, but what it suggests is that it is very difficult for them to understand these issues sometimes, and in general, I don't believe that juries serve plaintiffs well. I think plaintiffs have a really hard time in front of juries. It's a long process to get there, and even if plaintiffs are successful in front of juries, they then have to pay substantial amounts of money to move the case to that point to their attorneys in the event of a win.

On the other side of the ledger, these were cases that did not involve error but that were paid, we found the strongest predictor of that type of discordance is a case involving an infant, and the reasons for that, we think, are that attorneys are just not willing to put these cases in front of juries when they involve infants and have very sympathetic plaintiffs in that way. So merit, to some degree, is irrelevant in those settlements. There are cases that need to be paid because nobody is really willing to roll the dice with that court decision.

The CHAIRMAN. Thank you.

Mr. Howard, one of my biggest concerns about the current malpractice system is that it fails to capture information that I think could improve the medical delivery system. How does your proposal address that shortcoming of the current system?

Mr. HOWARD. Well, a key aspect of our proposal is to have the health court attached to an administrative body that would capture information not only from trials but also from settlements and sort through it to see what the lessons learned are and then disseminate the information that's important to disseminate to the medical community about things that are going wrong and possible fixes, not unlike the FAA, you know, when things go wrong; many more instances.

So there is a vital patient safety component trying to collect information and sort through it and then disseminate it to learn from our mistakes. And again, part of our proposal involves transparency, so, you know, I think it is important to—it's a vital part of the proposal.

Could I also comment, Mr. Chairman, about some other things, one thing that was said that I sort of mis-stated but——

The CHAIRMAN. We will give you a chance, give everybody a chance at the end to have a little wrap-up comment——

Mr. HOWARD. All right.

The CHAIRMAN [continuing]. On any of the things, and all of you can put any response to any question in writing for us, and we'll

make that a part of the record, too, because we don't always have the time to collect all those thoughts, but we want all those thoughts.

In your healthcare proposal, you would have the courts hire experts to testify on the complex medical issues. Can't courts currently bring in independent experts to guide the courts, and if not, why isn't it used?

Mr. HOWARD. Well, courts can do it today, but they infrequently do it, and I think part of the problem is who pays for it? And so, part of the funding for this proposal would have to include a budget for neutral experts. But I would also like to point out that our proposal does not preclude parties from having their own experts. But we think having a neutral expert will substantially decrease the probability of the kind of thing that happened to Susan Sheridan, where someone comes in with junk science, you know, in that case on the side of the doctor, because you have someone picked off a panel of approved experts who will be coming in with the best science.

The CHAIRMAN. For Ms. Niro, we've heard from other witnesses on the panel that most people injured by negligence don't receive any compensation. Under our current medical litigation system, we seem to be missing quite a few of them. Probably, they're less substantial cases, or the people are confused, or they don't have good representation. Does the ABA have a position on whether that's an acceptable aspect of the system?

Ms. NIRO. Senator, I'm not aware of any specific statement of ABA policy that directly responds to your inquiry. I do know that the ABA shares the concern that legal services be available to all of our citizens, and it is one of our major goals to ensure that that is, in fact, the case. Current situations now often prevent needy people from receiving the services of attorneys, and there is existing today a difficulty in assuring that attorneys are available to those cases that are most needy.

The CHAIRMAN. Thank you.

Kind of the same question for Mr. Vidmar, because in your written statement, you said that only 1 out of 7 patients who actually suffers a negligent injury files a claim. That seems to suggest that the current system is missing something, that it's failing in some way. And it seems to me to say that something needs to be done.

Mr. VIDMAR. Well, I agree; I agree with that response, and it is difficult to say. I don't know what the solution is for these kinds of cases. I am offering the view that the one thing that the tort system does do is that it sets up a standard which causes people to negotiate reasonably because of the ultimate threat of the jury trial.

For those people who are missing, I think it's a very sad set of circumstances that we have, and it may be that some of those injuries are relatively minor. I don't think anybody's really tested this in the sense of, you know, the 1 out of 7 that actually end up that closely, how seriously they were injured or whether, in fact, they had alternative resources. And that's not been looked at carefully, so that's just one of the pieces that's missing in the puzzle.

The CHAIRMAN. But would you say that a schedule of damages might bring more attention to less serious injuries, maybe even get

the attention of physicians a bit more, even send a more consistent message?

Mr. VIDMAR. Absolutely, and I think maybe the Michigan standard which we've been talking about here has been presented, I'm all in favor of that, because I think that we should be providing some compensation. And my feeling is it's probably cheaper in the end. I'd like to see statistics on how well that works out, because you don't have all the major litigation expenses, and I think a lot of people who get this say, "Look, you know, maybe I've got some advice from a lawyer, but I don't have to pay for the depositions and the travel to different parts of the country and all of those expenses."

It would be cheaper to do it that way, and yet, you are still protecting, if the parties can't agree, you are still protecting the right, the ultimate right, to trial by jury.

Ms. NIRO. If I may, the difficulty, I think, is assessing accurately what are those kinds of injuries that would be well addressed by the schedule. It's very difficult without looking at the individuals involved to say what is a minor problem, what is a major problem.

If we just thought about the difference in a person losing the operation of their hand, if it's, for example, my 79-year-old mother or a world-famous surgeon who has developed new operating techniques and taught the world's surgeons a better and faster and more efficient way to cure pain and suffering. I think that whenever we generalize any kind of injury, what is lost is our ability to appreciate that not all people have the same needs, and not all people will be compensated fairly when we generalize the approach.

The CHAIRMAN. That's why we're suggesting a medical court model.

Yes, Ms. Sheridan.

Ms. SHERIDAN. You know, in response to the data that shows that most people who experience medical error or harm don't end up with any award or don't end up even suing, I think a lot of it has to do with the fact in the United States, it's not mandatory to disclose medical errors, and a lot of people don't know that a medical error has taken place. For example, in Pat's situation, after he went in for his second surgery, and they took out the tumor, and they said this time, "it is a sarcoma; it's cancer," we were led to believe that it was a benign tumor that became cancerous.

But because of a series of doctors asking Pat why he never got treated for his first tumor, after the third doctor came in and said, "Wait a second, what was his pathology on the first one?" And they said, "Well, we don't know?" I went down to medical records. I checked out his file. And I found the pathology that got lost that indicated that it was a malignant synovial sarcoma.

Pat was discharged from the hospital with no one ever telling him that that error had taken place. I discovered the error. So I think that so many errors take place that are never honestly disclosed to patients, and therefore, if they don't know that an error takes place, and they had some type of adverse outcome, they're not going to file a lawsuit. So I think that in talking about solutions, you know, when there is a known, and sometimes there are gray areas undoubtedly, but when there is a known medical error

that especially creates harm, I think that we need to look at a law that mandates full disclosure.

The CHAIRMAN. Which brings me to Mr. Boothman, who is an advocate of people admitting when they did something wrong, and obviously, testimony to doctors willing to do that and that there are some good outcomes to it; I think most doctors in the country would be afraid to do that, but Mr. Boothman, what do you see as the obstacles to applying the system a little bit more broadly, especially in systems that are less uniform, like small, independent pediatric practices in New York City or rural Wyoming?

Mr. BOOTHMAN. I think the single biggest obstacle is the fear of financial ruin and/or losing insurance coverage because the physician makes a decision to disclose something, not knowing what the ramifications are going to be. I do have a luxury that a lot of people in my position don't: I have the luxury of being able to say to our physicians, the State of Michigan will stand behind you. You don't face financial ruin in doing the right thing. And I think that's the single biggest obstacle that prevents most physicians from doing what they really want to do.

You know, one of the most interesting experiences we've had is once we got past the initial shock and awe of the suggestion that the doctor would actually sit down with a lawyer who is threatening to sue him and just have a conversation, what we've really found is most of our physicians welcome the opportunity. They don't shy away from it. But they needed permission, and they needed assurance that it wasn't going to somehow ruin them.

I suggested to the State of Ohio, which has been through some insurance crises, and I mentioned this in my opening remarks; I don't understand why States have not pulled together a catastrophic injury protection. I think it can be done. I've spoken with insurance people who believe that an umbrella policy that can be created with very attractive premium rates, and I would, if I were doing it, I would key that, key participation in that fund to an agreement to submit charts for quality assurance reviews or submit themselves for peer reviews should there be any claims.

I think what you'll find is similar to our experience: that the big cases drive the numbers. The catastrophic injury fund would have widespread participation but would only be tapped by a minority of doctors who needed to do that. And if I were designing a system to foster that open and honest disclosure, I'd first take care of that. I'd get an umbrella policy that would take care of the catastrophic loss. I would make the premiums attractive. I think you'd get widespread buy-in. I'd connect that up with some peer review and quality assurance participation and then require physicians to disclose those errors.

Our experience at the University of Michigan is that it's been embraced across the board once they got permission, and frankly, permission from a lawyer. Lawyers like me have been telling doctors for a very long time not to say anything, and it's deeply ingrained. The number of doctors I've spoken with who believe they can even lose their insurance coverage just by talking to their patient is surprising to me and troubling.

The CHAIRMAN. You also mentioned in your testimony that you learned the difference between appropriate and negligent care. Can you describe how you developed that knowledge?

Mr. BOOTHMAN. Actually, I haven't developed it. We have created a pretty nice infrastructure which allows us to understand, come to an understanding on our own. You know, when a pediatrician decides that he or she is going to prescribe an antibiotic for a patient with a first ear infection, there is no way that that doctor knows whether that patient is going to be back 2 days with a catastrophic reaction to that, and we've had those cases, frankly.

The practice of medicine is inherently dangerous, and that's why I think you can't treat it like you might a worker compensation scheme. It's inherently dangerous, and it involves a complex set of judgments. What we do is we get reviews when we have a patient injury come to our attention, whether it's a claim or whether it's just a patient injury. And we interview the staff involved; we have internal and external reviews, and we have a system by which that case is actually reviewed by a medical committee, and that gives me guidance as to what direction we should go.

We always open the issue up for discussion after that, and sometimes, I find myself explaining to patients why their complication is simply not the result of medical negligence, and other times, we sit down, and we say right up front we're sorry; this should not have happened, and let's move to a discussion of compensation.

I have seen it both ways. One of the things I've seen is that I think that the American public is much more forgiving if given a chance, if given a chance to understand the challenges doctors have faced in that care. And that's something that's been missing, that conversation, that sharing of how difficult this surgery was.

As an example, we have a cardiac surgeon on faculty who probably does more heart valve surgeries than anyone, and he takes the hopeless cases. And after his third patient complaint, he said to me, "I don't get these people: they think that after I do my surgery, they're going to be running in the Olympics, when they've really abused themselves for 50 years, and they've got compromised hearts." And I said to him, "Do you realize why? Because you walk in, and you say 'hi', I've done more of these than anyone else; you can have infection, bleeding, or damage, but it's not going to happen to you," and that's the message that they hear.

The communication part of this is really important both before medical care and then after a catastrophic injury occurs. And if we stay in the saddle with people, people are a lot more forgiving than we think.

But one of your earlier questions was how do we handle the problem of patients with—the huge number of patients who have medical errors and never get compensated. And I had two responses to that. One of them was, first, you're assuming that everybody believes they should be compensated, but that's not our experience. We've had people who have even had loved ones die, but when they understand that we are accountable, and they understand that their questions got answered, and they understand that we've made changes so that it won't happen again, they don't all believe they need compensation. They're satisfied at that point.

And second, it depends on how you define medical errors. In our institution, for instance, probably the most prevalent medical error is medication administration. And yet, the incidence of injury from inappropriate medication administration is exceedingly low. It depends on how you define that. So if a physician says you should get a medication every 4 hours, and it comes 4 hours and 15 minutes later, we characterize that as a mistake, but that 15-minute delay probably made no difference in the care.

So I think you have to be careful when you ask those questions and understand how to process that information.

The CHAIRMAN. Thank you.

Mr. Sage, some people have criticized the health courts and other ideas similar to that as inappropriately denying patients the right to a jury trial and have said that it would lead to inadequate compensation for injured patients. In light of the studies that you've seen that show how our current court system and jury trials perform and the amount of money that goes to the lawyers on both sides, how valid do you find the concern? How would you comment on that?

Mr. SAGE. Well, let me start, Mr. Chairman by saying that I think everyone who is testifying here as an academic researcher does superb work: Dr. Studdert, Professor Vidmar. But there is somewhat of a difference in perspective between the way I've looked at these issues and the way that Dr. Vidmar, for example, presents his work. His book, as he told you, is called Medical Malpractice and the American Jury, and my book is called Medical Malpractice and the U.S. Health Care System.

I tend to look at these issues not as issues of whether or not to dismantle a jury system or curtail its use but as opportunities to build something into the healthcare system that has never been in the healthcare system before, which is a way of dealing promptly and compassionately and fairly with injury as well as preventing injuries that occur.

I don't have good empirics on this, but I have good anecdotes in the sense that most plaintiffs' lawyers that I've talked to have suggested that a plaintiff who does not have at least $200,000 in recoverable damages won't be a case that that attorney will accept. That leaves a lot of room, I think, for people to participate in a much, much better system who would never benefit at all from the existing system of civil justice.

The Medicare population, for example, falls squarely into that distribution. These are people who file malpractice claims far less frequently than younger patients, who recover less money if they do file a claim. In Texas, we looked at all of the malpractice payments, both trials and settlements, over a 15-year period, and I could give you the regression analyses, but I'll content myself with one piece of information, which is that if you list out the 100 largest malpractice payments over a 15-year period in Texas, only one involved a person over age 65. There is a population that is really not seeing benefits from the existing system.

I also think that in bills such as yours that fund Federal demonstrations of all of these approaches, you're not stacking the deck against claimants. You're saying let's create a system that we think is going to work well for everybody, and let's test it and see how

much it costs and what benefits it provides. And under those circumstances, I really don't see that any of these proposals is taking anything away from anyone.

The CHAIRMAN. Thank you. I have a number of other questions here, but I was just handed kind of an emergency note, and I had said that I would let you each have a wrap-up comment. Could I get you to put those wrap-up comments in writing for us? I will look at them, and I'll distribute them to the rest of the committee, too, but I am going to have to leave. And I apologize profusely.

This is one of the most valuable panels that I've ever had, some of the most diverse opinions that I've ever had assembled, and a body of knowledge that I think Senator Kennedy and I can use to perhaps put something useful together. It probably won't be the original concept, but it might be. It will have some variations. But the record will be open for 10 days, so you don't have to do that immediately, and the 10 days is also so that members of the committee can submit questions, and hopefully, you'll answer those, too. My appreciation for your time and your answers, and I look forward to more information from you.

So this meeting is adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF SENATOR CLINTON

I'd like to thank Chairman Enzi and Senator Kennedy for convening this hearing today to examine alternative proposals in the medical liability reform debate.

Today, I hope that we can begin to move past the traditional divisions in this debate to discuss ways that will, in the long run, serve patients, physicians, and the healthcare system as a whole.

I hear first hand, from families who've experienced errors in their care and from doctors who have experienced escalating insurance costs. This is a real problem that deserves both serious consideration and realistic solutions.

We all know the statistic from the landmark 1999 Institute of Medicine Report that as many as 98,000 deaths per year result from medical errors. But what you hear far less is that the vast majority of these errors are not due to the negligence of physicians, but to failed systems and procedures.

We need to reduce medical errors for patients and physicians by incentivizing and designing better systems. We need to shift our attention from blaming doctors and hospitals and focus our efforts on modifying and improving systems to reduce medical errors and to enhance patient safety.

Instead of ending up on the court house steps, we need to find a way to prevent and resolve problems proactively, not reactively.

Understanding the root causes of these systemic errors requires, first of all, their disclosure and analysis. Herein lies the fundamental tension between the medical liability system and the goal of providing high quality care and improving patient safety.

Studies have consistently shown that healthcare providers are understandably reluctant to engage in patient safety activities and be open about errors because they believe they are being asked to do so without appropriate assurances of legal protection.

Senator Obama and I co-authored S. 1784, the *National Medical Error Disclosure and Compensation Act*, or MEDiC Act, to address this fundamental tension. The bill is designed to bridge the gap between medical liability and patient safety systems for the benefit of both patients and physicians.

With better communication, more cooperation and protection from liability within the context of the MEDiC program, we provide doctors and patients with options to find solutions outside of the courtroom, which the vast majority of patients say they are looking for.

The MEDiC Act will improve patient safety and the quality of healthcare while protecting patient's rights and providing liability protection for healthcare providers who participate in the program, to reduce both medical errors and lower malpractice costs.

The MEDiC Act is based on successful programs operating around the country in places like a Children's Hospital, a private insurance company, a Veteran's Affairs hospital in Kentucky, and the one we will hear about from Mr. Rick Boothman at the University of Michigan Health System.

These programs have improved systems to not only prevent future medical errors, but also to lower malpractice costs and claims.

Through this model we can meet the four fundamental goals that I believe must be a part of any successful medical liability reform:

- Reduce the rates of preventable patient injury;
- Ensure that patients have access to fair compensation for legitimate medical injuries;
- Reduce liability insurance premiums for providers; and
- Encourage open and safe communication between providers and patients.

I look forward to hearing from our expert panel with special thanks to Rick Boothman whose program is largely the basis for the MEDiC Act. I hope that with his input, we can begin considering common-sense alternatives to medical liability reform.

QUESTIONS OF SENATOR CLINTON FOR MR. BOOTHMAN

Question 1. Mr. Boothman, in your written testimony, you briefly mention the importance of distinguishing between reasonable and unreasonable care. Based on your experience with the University of Michigan's program, why have you found this to be important and why is it so difficult to know the difference between reasonable and unreasonable care? Can you contrast this concept in the context of your program with other alternatives discussed during the hearing?

Question 2. Mr. Boothman, your written testimony states, "radical proposals like scrapping our tort system must give way to detailed, focused efforts designed to reach the real problems." Can you summarize these problems? Based on your experience, what changes do you suggest that would maintain our current system while addressing these problems?

Question 3. Mr. Boothman, why in your opinion does the University of Michigan program work? What factors contribute to its success and are they reproducible elsewhere? How?

Question 4. Mr. Boothman, your written testimony asserts that alternatives explored during the hearing will not work. Can you elaborate? Why do you think these models are not in the best interest of the medical community?

Question 5. Mr. Boothman, how important is it that those involved feel that they have gotten justice from whatever system is employed to address patient complaints and patient injuries?

Question 6. Mr. Boothman, how have the changes in the University of Michigan Health System's approach been received by your physicians and patients?

[Editor's Note-Responses to Senator Clinton's questions were not available at time of print.]

RESPONSES TO QUESTIONS OF THE COMMITTEE BY DAVID STUDDERT

Question 1. I reviewed the recent article in the New England Journal of Medicine outlining your research findings with great interest. In that article, you and your fellow researchers state:

> "Our findings point toward two general conclusions. One is that portraits of a malpractice system that is stricken with frivolous litigation are overblown . . . 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."

Your study also determined that:

> . . . nonpayment of claims with merit occurred more frequently than did payment of claims that were not associated with errors or injuries."

You elaborated on this point in your written testimony to the committee, stating,

> . . . claims with error and injury that did not receive compensation was substantially more common. One in six claims was an unpaid error."

I think those findings are very significant. They contrast sharply with the negative stereotypes we often hear about the jury system. In essence, your research shows that most of those injured patients who are recovering compensation in the

current judicial system, both through judgments and settlements, deserve the compensation that they receive. The problem that you identify is that other injured patients, who also deserve compensation, are not receiving it.

I agree that is a legitimate concern. Interestingly, it is exactly the opposite of what most tort reformers claim the problem is. They claim that too many injured patients are being compensated. Assuming that your findings are correct, the last thing we should be doing is considering alternatives that would take rights away from injured patients or that would limit the amount of compensation they receive for their injuries. We need to expand the number of injured patients who receive compensation, while not reducing the level of compensation that the most severely injured patients receive.

Many of the proposals to replace the jury system with some version of an administrative system are *not* designed to expand compensation to more injured patients, but to arbitrarily reduce cost at the expense of victims. What safeguards would you propose to protect the rights of injured patients to receive the full and fair compensation that they deserve?

Answer 1. The general finding from our recent study was that in approximately 75 percent of claims the litigation outcomes were concordant with their underlying merits. How far one can take this result in inferring that the system's accuracy is adequate is disputable. (Discordant outcomes in 25 percent of cases may, for example, still cause substantial unpredictability.)

The first part of the question is a fair summary of one of the more specific findings from the study, and from earlier work we have done on the issue of "undercompensation."[1] There is strong evidence from epidemiological studies[2] that many patients—in fact, most patients—who experience negligent injury do not obtain compensation. This population consists of both unsuccessful claimants (the "1 in 6" figure referred to in the question) and patients who never come forward with a claim.

I believe the current system's inability to address the needs of this deserving yet underserved population is a serious blight on its record. We can and should do better for these patients.

The proposal for an administrative alternative that I am familiar with has done better in this regard as one of its central goals. I am therefore unsure about the "many proposals" to which the question refers which are not designed to do this, and which aim to "arbitrarily reduce costs." I am not familiar with these proposals and so cannot comment on them.

The health court model that our research group has been developing[3] certainly does not fit this description, and I would oppose any proposal that did. Indeed, in previous work, I have criticized some tort reform measures for precisely this reason.[4] The model proposal aims to compensate more patients than the current system does in three main ways:

(1) By incentivizing providers to be forthright in informing patients when a potentially compensable injury occurs (and penalizing them if they do not).

(2) By creating a pathway to claiming that is simpler, more user-friendly, and easier to navigate than the current system's.

(3) By using a more generous standard of compensability, namely "avoidability" instead of negligence. An avoidability standard would, by definition, render every claim that meets the negligence standard eligible for compensation, plus some claims that would not be eligible under a negligence standard, thereby expanding the pool of injured patients who would qualify for compensation.

Question 2. Thank you for your testimony and for providing us with a novel perspective on how we might approach medical injury from the perspective of improving patient safety. I could not agree with you more that the current system is not accomplishing these most important goals for fair compensation and reduction in errors. A lot of informed people think that the true number of medical errors and injuries is far greater than the current number of malpractice law suits. Have you had an opportunity to do cost projections for your proposal. If we provide compensation

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[1] Studdert DM, Mello MM, Gawande AA, et al. Claims, errors, and compensation payments in medical malpractice litigation. N Engl J Med 2006;354:2024–2033.

[2] Localio AR, Lawthers AG, Brennan TA, Laird NM, Hebert LE, Peterson LM, Newhouse JP, Weiler PC, Hiatt HH. Relation between malpractice claims and adverse events due to negligence. Results of the Harvard Medical Practice Study III. N Engl J Med. 1991;325:245–51; Studdert DM, Thomas EJ, Burstin HR, Thar BI, Orav EJ, Brennan TA. Negligent care and malpractice claiming behavior in Utah and Colorado. Med Care 2000;38:250–260.

[3] A detailed outline of the model appears as an attachment to my written testimony.

[4] Studdert DM, Yang YT, Mello MM. Are damages caps regressive? A study of jury verdicts. *Health Affairs* 2004;23:54–67.

for every injury will this increase or decrease the overall amount spent on medical malpractice?

Answer 2. In a previous study of medical injury in Utah and Colorado, our research group estimated the costs of compensating avoidable injuries (as opposed to negligent injuries) in an administrative compensation model.[5] The bottom line of these projections was that the administrative model, which is similar in many ways to the health court model we have proposed, would cost around the same or slightly more than the current tort approaches in those States, while compensating a much larger number of injuries. How is this possible? Savings in administrative costs, as well as some savings in the size of some large awards, would free up moneys to be distributed to more injured claimants.

Our research group is in the process of calculating new cost estimates specifically tailored to the health court model we have proposed. We hope to have the work completed by Fall, 2006. We hypothesize that this work will produce similar results to the research in Utah/Colorado—namely, it will not cost less than the current system and may well cost a little more. But the issue of value is important: how many patients will be compensated under the alternative approach, how accurately, how quickly, and how efficiently, compared to the current system? And how stable and predictable will the system be? On all of these measures, I think there is a good chance the health court will come out ahead.

The last part of the question raises one additional point. It is unrealistic to expect that any compensation system will compensate every eligible injury. No existing system does that—not even pure no-fault models like auto injury compensation schemes. There will always be some injured persons who simply don't want compensation, or who choose not to come forward, for whatever reason. And sometimes a compensation system will "get it wrong" and deny compensation when it should have awarded it. But again, the question is what proportion of eligible persons will find their way to compensation and how often will the system "get it right." We believe that an administrative model, such as a health court, could surpass the *status quo* on both counts. Indeed, it would be tough to do worse than the current malpractice system, where about 3–5 percent of eligible patients obtain compensation.

Question 3. As a follow-up, you also propose an entirely new nationwide court system for adjudicating medical injury issues. This seems unusually complex and costly. Do you have a fall-back plan to achieve your goals without such a specialized change in the structure of our court system?

Answer 3. The proposal to which I have testified—and which I understand is on the table—is for a demonstration project, or group of demonstration projects, to test the efficacy of alternatives to the current tort liability system, not a new nationwide system. To roll out an alternative approach nationwide overnight would be premature. There needs to be an opportunity to test the potential advantages of an alternative against the current system.

I agree that the health court model we have developed is not simple. Compensating medical injury in a fair and consistent way, and ensuring that the interests of patients are safeguarded in the process, is not a straightforward undertaking. A bare-bones proposal would therefore leave important issues unaddressed. The appropriate comparison, however, is to the current system, which I believe is much more complex than the type of alternatives under consideration.

I addressed the issue of costs and cost estimates in a previous question. We believe that the proposed alternative would cost about the same, or slightly (not dramatically) more than the current system. It is unlikely to cost much less. But additional costs, if there are any, should be assessed in terms of their value. Does the system compensate more patients and is it predictable in ways that allows the wider healthcare system to operate more efficiently?

With respect to reforms besides the health court, I mentioned in my oral and written testimony that there are a variety of innovative alternative dispute resolution (ADR) approaches. I believe a number of these warrant serious consideration. The "Early Offer" concept, for example, has the potential to avoid the passion play and high cost of full-blown litigation. In general, these ADR approaches are less ambitious than health courts because they merely overlay the existing, dysfunctional negligence system, with attempts to streamline the adjudication process. Thus, in my opinion, they do not carry the same potential for broad system improvement.

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[5] Studdert DM, Brennan TA. No-fault compensation for medical injuries: the prospect for error prevention. JAMA 2001;286:217–223; Studdert DM, Thomas EJ, Zbar BI, Newhouse JP, Weiler PC, Brennan TA. Can the United States afford a no-fault system of compensation for medical injury? Law Contemp Probs 1997;60:1–34.

Nonetheless, reducing the time and cost of litigation in this way would likely be a useful step forward, and in this regard, they are likely to be productive reforms.

Question 4. One of my biggest concerns is that doctors are not learning from medical malpractice cases. In other words, doctors have lost so much faith in the reliability of our system that it no longer serves as an effective deterrent to mistakes. In your study did you find that the variability of the verdicts made people less willing to study and learn from their mistakes?

Answer 4. Our study did not address the issue of deterrence or the quality improvement dimensions of the tort system. I agree that this is a serious concern with the tort system. In a previous study, however, my colleagues, Michelle Mello and Troy Brennan, conducted what is widely-recognized as the seminal review of the evidence relating to deterrence in the medical malpractice context.[6] Their basic conclusion is that there is virtually no evidence of a deterrent or quality improvement effect. This is unfortunate, given that deterrence is one of the system's founding rationale.

Clearly, any significant reforms in the area of medical injury compensation must address patient safety. This is a critical issue. We do not know for sure whether an alternative approach to compensation, such as health courts, will do better in terms of deterring substandard care and promoting high quality care. There is good reason to think it might, and in a recent paper we outlined a variety of ways this may occur, ranging from collection and analysis of critical data on injuries to dissemination of "best practice" guidelines derived from adjudicated cases.[7] A health court approach, along the lines we have described, offers considerable promise in this area. But once again, the proof will be in the pudding. Only the launching of demonstration projects, time, and careful evaluation can reveal the extent to which the promise is realized.

RESPONSE TO QUESTIONS OF THE COMMITTEE BY WILLIAM M. SAGE

Question 1. Dr. Sage, your comment on one of the problems with the current tort system is that it focuses on the individual physician and not on the environment, the team or the process that may lead to a medical error. Modern healthcare is clearly a sophisticated and complex process that involves multiple inputs from a variety of health professionals, institutions and technologies and the cause of errors and bad outcomes is not always individually attributable. Given this diffusion of blame, who should shoulder the cost of medical malpractice and medical error under the systems envisioned by you and other panelists today?

Answer 1. As an empirical matter, rising liability costs during malpractice insurance crises tend to be absorbed by patients, private health insurers, and government payers such as Medicare, much as those parties absorb cost increases in other inputs to medical care. In the 1980s crisis, Professors Mark Pauly, Patricia Danzon, and Raynard Kington studied the economic incidence of rising malpractice premiums, and found that physicians quickly passed those costs on to patients and payers through fee increases. In a study I co-authored, Professor Pauly recently revisited that question with respect to the current crisis, and found that physicians today still pass premium increases on to patients and payers, but through increasing the volume of services because government fee schedules and private managed care prevent them from simply raising fees. What we do not know, however, is whether the additional services are mainly necessary ones or mainly unnecessary ones.

I believe that the financial burden of medical malpractice is largely determined by the demands we place on our healthcare system and the value we ascribe to that system's various features. The cost of malpractice therefore should mirror the burden of general health expenditures. This is a difficult social decision, on which no consensus has yet been reached.

Whatever our beliefs about the role that government should play in the healthcare system, we can agree that waste in the malpractice system, whether from unnecessarily high rates of medical errors or excessive administrative costs, should be reduced just as waste in the healthcare system should be reduced. We can also agree, I hope, that it is inefficient to ask physicians, who capture at most 15 percent of overall healthcare revenues, to finance liability insurance for the entire healthcare system, and to burden a few "high-risk" physician specialties with the lion's share of those costs when all that does is increase the volatility of malpractice premiums

[6] Mello MM, Brennan TA. Deterrence of medical errors: theory and evidence for malpractice reform. Tex Law Rev. 2002;80:1595–1637.

[7] Mello MM, Studdert DM, Kachalia A, Brennan TA. Health courts and accountability for patient safety (in press: *Milbank Quarterly*, 2006).

and the dual threats that physician exit and defensive medicine pose to healthcare access and quality.

Because of these issues, I believe that a better malpractice system would rely for liability coverage more on the insurance purchasing decisions of large, diversified providers of healthcare services, such as hospitals, that can also more effectively prevent medical errors. A better system also would ask the public, through government, to shoulder the burden, after open debate, of caring for severely impaired newborns and other patients whose tragic situations are not really about medical error. And a better system would take advantage of the Federal Government's strength as a reinsurer, making stop-loss coverage available at reasonable cost to healthcare providers when commercial reinsurance markets tighten.

Question 2. It often stated that the current litigation climate leads to defensive medicine that contributes to the rapidly rising cost of healthcare. Do you think that reforms of our approach to medical liability will change such practice or has it been incorporated into our medical curriculum and into the apprenticeship of internship and residency such that it will not reverse or will do so only very slowly?

Answer 2. I think it is important to distinguish defensive medicine that exists as a background constraint in the healthcare system between malpractice insurance crises from defensive medicine that spikes along with spikes in insurance premiums during malpractice crises. I believe that background defensive medicine is a significant factor in the long-term cost and structure of healthcare, but that it is so deeply entwined in issues of medical culture, healthcare reimbursement, and patient preferences that there is no single quick fix.

By contrast, I believe that the current malpractice insurance crisis has resulted in particularly worrisome defensive practices that require immediate attention. Physician perceptions of the malpractice system during crisis periods affect patients. Research published in JAMA, reflecting work I did with Dr. David Studdert and his colleagues at Harvard, revealed very high levels of self-reported defensive medicine among "high-risk" specialists in Pennsylvania. These physicians explained in great detail how their fear of losing malpractice coverage led them to overtest and overtreat some patients, while refusing care to others. One major concern is the effect on women's health of having ob-gyns limit access to high-risk obstetrics while surgeons and radiologists perform large numbers of mammograms and biopsies they consider medically unnecessary. Another major concern is that a hostile malpractice environment seems to disadvantage assertive patients who are involving themselves in their care exactly as patient safety advocates urge them to. In our study, physicians often reported refusing to care for assertive patients because they viewed them as litigious, or else simply indulged their initial requests for expensive, sometimes invasive, tests and procedures rather than working in partnership with them.

These shorter-term trends can be reversed, I believe, if marketing and rating practices for malpractice insurance are placed on a more secure footing than has been the case since the 1970s, and if physicians see that more predictable and compassionate systems than conventional malpractice litigation are possible. Physicians' skepticism about malpractice liability is deep-seated, however, and any commitment to meaningful reform must be credible to them. This is why I believe that demonstrations of malpractice reform must include systems of early disclosure and fair compensation to which patients commit themselves prior to treatment, rather than after injury has occurred.

Question 3. You mentioned in your testimony that Pennsylvania might apply for a demonstration grant if S. 1337 was enacted. Are there any other impediments that need to be removed prior to trying an alternative in a State like Pennsylvania?

Answer 3. I think that a Federal "hold-harmless" assurance is the most important incentive for healthcare providers testing malpractice reform at the State level. Malpractice experts agree that any successful demonstration must identify more errors and offer compensation to more patients than currently occurs in litigation, and States and providers reasonably worry that this will increase their costs. With a Federal assurance that any excess costs will be covered during the test period, States can design fair tests. Without such an assurance, I fear that demonstrations will be biased against patients, and will seldom gain acceptance for that reason either from patients or from the political process.

Other impediments exist that, while smaller, might endanger a successful demonstration program. For example, State law varies in its protection of mediation proceedings and voluntary apologies from exploitation in subsequent litigation. Both of these procedural innovations are central to a successful malpractice demonstration. Participating providers might also want assurances that State health regulators fully support a demonstration and would not engage in heavy-handed enforcement

activities in response to greater provider openness about errors. And participating States might also want to sort out in advance any objection that the State judiciary might have to legislatively enact reform of litigation procedures. All of these issues have had some relevance to Pennsylvania's reform experience, though I do not think that any of them would prevent a successful demonstration in Pennsylvania if Federal funding became available.

RESPONSE TO QUESTIONS OF THE COMMITTEE BY PHILIP K. HOWARD

Thank you for the opportunity to respond to questions by members of the committee and to provide supplemental testimony.

Question 1. As a follow-up, you also propose an entirely new nationwide court system for adjudicating medical injury issues. This seems unusually complex and costly. Do you have a fall-back plan to achieve your goals without such a specialized change in the structure of our court system?

Answer 1. Our proposal is for pilot projects only, to test the possible benefits of an administrative compensation system. If the benefits prove to be great—for example, (1) providing a fairer and more efficient compensation system for injured patients (2) improving transparency and aligning incentives toward patient safety and (3) starting to overcome the culture of defensiveness and waste—Congress might conclude that shifting to special health courts is, indeed, worth the effort. Again, many important agencies concerned with the quality of healthcare—including the Institute of Medicine and Joint Commission on Accreditation of Healthcare Organization—have called for pilot projects.

Rather than a nationwide system, we expect that Congress might impose requirements for a system that met certain criteria (for example, consistent rulings on standards of care instead of ad hoc verdicts) and let the States meet these requirements in their own way.

Question 2. I appreciate the work that you have been doing with Mr. Studdert and Dr. Brennan. While much more sophisticated, there are some parallels of your proposed health courts with a variety of arbitration panels that have been set up and tested for addressing medical injury. Yet these arbitration panels and boards have not achieved widespread utilization or success. Why have they failed? Are any elements of these concerns relevant to the success of your health court proposal?

Answer 2. The core feature of the health court model is that it provides written rulings on standards of care as a matter of law. Only when an official body takes this authority can we aspire to the consistency needed to restore trust and align incentives. In this critical respect the health court model differs from both screening panels and arbitration panels.

Screening panels do not have the authority to adjudicate claims. Evidence suggests that screening panels do not reduce, and may increase, the number of claims filed.[1] They also have little or no impact on the incentive to file claims for the purpose of obtaining a settlement. Screening panels are used by some lawyers as a way to evaluate the claim. In tragic situations, such as babies born with birth defects, lawyers ignore the opinion of the panel and sue anyway. By contrast, health courts would diminish the incentive to file invalid claims by establishing and enforcing reliable standards of care.

Arbitration can be a productive way of resolving disputes, but there is little empirical evidence to support that finding for medical malpractice cases.[2] Arbitration does little or nothing, however, to provide guidance to improve healthcare or otherwise align incentives toward better quality and avoidance of waste. As with jury verdicts, arbitration is an ad hoc system, without written rulings or any aspiration for consistency.

Question 3. One component of your written testimony points to the role of health courts in developing legal standards of medical care. Do you really think they are

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[1] R. Hanson, B. Ostrom, and D. Rottman, "What Is the Role of State Doctrine in Understanding Tort Litigation" *Michigan Law and Policy Review* 1, no. 1 (1996): 43–72; S. Shmanske and T. Stevens, "The Performance of Medical Malpractice Review Panels," *Journal of Health Politics, Policy and Law* 11, no. 3 (1986): 525–535; P.M. Danzon, "The Frequency and Severity of Medical Malpractice Claims: New Evidence," *Law and Contemporary Problems* 49, no. 2 (1986): 57–84. (cited in C.T. Struve, "Improving the Medical Malpractice Litigation Process," *Health Affairs* 23, no. 4, 35).

[2] E. Rolph, E. Moller, and J.E. Rolph, "Arbitration Agreements in Health Care: Myths and Reality," *Law and Contemporary Problems*, 60 (Winter & Spring): 153–184, 1997. See also T.B. Metzloff, R.A. Peeples, and C.T. Harris, "Empirical Perspectives on Mediation and Malpractice," Law and Contemporary Problems, 60 (Winter & Spring): 107–152, 1997.

the most appropriate group to define such standards? Will these standards be regional or national in application?

Answer 3. In our proposal, health court judges would define the standard of care in medical injury cases. They would do so in reliance on neutral experts—retained and compensated by the court—who would provide unbiased testimony on the standard of care. In general, there is a national standard for most medical practices. But in certain situations the circumstances can be important as well—for example, a general practitioner treating a head trauma victim in rural setting may not be held to the same standards as, say, a neurosurgeon in Boston. There might be differences among health courts in different States. But we expect that these variations will be minor. To help health court judges reach consistent decisions from case to case, judges would consider past health court decisions as well as clinical practice guidelines based on evidence-based practice standards, such as those disseminated by the National Guideline Clearinghouse at the U.S. Agency for Healthcare Research and Quality.

Question 4. One of my biggest concerns about the current malpractice system is that it fails to capture information that could improve the medical delivery system. How does your proposal address this shortcoming of the current system?

Answer 4. The health court proposal is designed to work in tandem with patient safety agencies which would capture and disseminate information about mistakes and errors, and develop recommendations on improving practices. De-identified information from the adjudication process would be transferred to patient safety authorities, providing the basis for analysis about adverse events and near misses that could aid in the development of strategies to prevent errors from occurring in the future. Information from the adjudication process would also be provided to healthcare providers so that they could conduct root cause analyses of what went wrong, and why.

Changing the culture of defensiveness and concealment is also a critical link toward improving patient safety. Creating a court which aspires to reliability will significantly reduce the fears that drive counterproductive behavior. Liberalizing the standard of recovery toward one of avoidability rather than error also lessens the emphasis on individual fault and better takes into account the role of system failures in leading to injuries.

SUPPLEMENTAL TESTIMONY

The distinguished panel of witnesses at the June 22 hearing provided a range of perspectives. Two witnesses offered opinions which reflected misunderstandings about the proposal for health court pilot projects, which I would like to correct.

Cheryl Niro from the American Bar Association stated that the health court proposal includes "the creation of a schedule for the assessment of damages and would cover both economic and non-economic damages." Several other times both she and Senator Kennedy made statements that implied that patients injured by medical mistakes would not get an "individualized determination of compensation" or "fair and just compensation." Ms. Niro suggested that the surgeon who lost a hand would get the same damages as people who did not rely upon their hands for their livelihood.

While there are many ways of structuring damages for pilot projects, our recommendation is for the victim to receive 100 percent of all monetary losses, including lost wages—thus, a surgeon who lost his hand and could no longer operate might receive millions, while a politician or a lawyer who could continue to practice would receive far less. Because lawyers fees would be dramatically lower in the expedited health court proceedings than the standard 33–40 percent (fees would probably be calculated as a multiple of actual investment in hours and costs), the actual damages that many injured patients take home is likely to be *greater* than under the current system. Health courts are also expected to provide compensation to many more injured patients, who are today shut out from the system because of the exorbitant cost. As Professor Studdert observed, over half of the malpractice dollars today goes to lawyers and administrative costs.[3] This is a shocking figure, nowhere addressed in the testimony on behalf of the American Bar Association.

For "pain and suffering" damages over and above monetary losses, we recommend creating a schedule depending on injury, as other industrialized nations do. The advantages of the schedule would be to create "horizontal equity" among patients with

[3] D.M. Studdert, Testimony before the Senate Committee on Health, Education, Labor, and Pensions, "Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006, p. 4; D.M. Studdert, et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine*, 354;19 (May 2006): 2031.

similar harms—would the surgeon who lost his hand have more pain than the worker on the assembly line, or the elderly retiree? Scheduling pain and suffering has the advantage of "turning down the heat" in disputes—reducing the uncertainty of what's at stake and alleviating the fears of catastrophic verdicts that skew physician behavior in ways that undermine quality and raise costs.

Professor Vidmar stressed the lack of evidence supporting the proposition that limitations on noneconomic damages would make malpractice insurance more affordable. But our goal is not to limit claims—we believe many more injured patients will receive compensation in our health court proposal—but to align incentives for better quality and avoidance of wasteful "defensive medicine." Only by doing pilot projects can we demonstrate what the actual effects will be. That's why we need them.

RESPONSE TO QUESTIONS OF THE COMMITTEE BY CHERYL NIRO

Question 1. Ms. Niro, thank you for your testimony representing the American Bar Association. You have suggested that many of the concerns brought forward today can be addressed by various voluntary alternative strategies such as arbitration panels. Yet despite being around for more than 3 decades, such approaches have not become widespread. Why do you think that is the case?

Answer 1. I would not wish to endorse the idea that alternative dispute resolution methodologies are not widespread. I believe that they are used extensively across the country. Statistics demonstrate that an extraordinarily small number of cases filed proceed to a judge or jury finding. They are resolved at some point prior to a trial court conclusion. And, of course, a percentage of trial courts are reversed and/or modified on appeal. Professor Vidmar's specific research in Illinois showed that only two cases in the counties he examined resulted in jury verdicts over $1 million in 2 years and one of those overturned was on appeal. I would refer you to the study he did using the records of the Madison/St. Clair County court records. See *http://www.isba.org/medicalmalpracticestudv.pdf.*

It is also important to remember that negotiation, mediation and arbitration are generally private and confidential proceedings by agreement of the parties. These options are often sought by the parties because they will not result in a public record. Some court systems do offer court annexed mediators and arbitrators, but even in those programs the parties are usually given the option to find an ADR process and ADR professional on their own, rather than using what is made available by the court.

There are a number of competing factors which affect the decision to use ADR in medical malpractice cases. After a series of meetings with the leaders of the medical community and their insurers, I have learned that there is little willingness to resolve these cases via any settlement procedure. The medical community is quite reluctant to have to report any dollars paid out in malpractice payouts to injured patients because of the national database that compiles and publishes that information. Competition in the healthcare industry makes any such reporting "bad for business" understandably, and there is an inherent conflict present in the decision to settle or litigate due to this factor.

Lawyers are ethically bound to present all options for resolving disputes with their clients and may be prosecuted in a disciplinary proceeding for failing to do so. Injured patients would rarely wish to prolong any adversarial proceeding, nor would their lawyers. Costs and time present difficulties for injured patients.

Insurers have an entirely different set of issues affecting their participation in these cases. They must reserve the moneys that could be awarded to an injured patient. But, the longer the moneys are preserved in the reserve account, the company continues to benefit from the interest accrued. On the other hand, some insurers are quite open to quick resolution, and may show reduced payouts over time because the injured patient and their lawyers have not had to pay out enormous sums in preparing for trial.

I firmly believe that there are a number of reforms to improve the collection and reporting of data, such as the data bank on dollars paid by the medical institutions in malpractice claims, which would result in positive change.

Question 2. A great deal of testimony today by some very thoughtful people has suggested that the current medical litigation system does not begin to deal with true patient safety and instead, often works in the opposite direction by preventing open reporting and open discussion. How do you counter the vivid evidence and testimony presented today?

Answer 2. Forward thinking medical institutions, such as the model in place in Ann Arbor, Michigan dramatically demonstrate that early, open discussion and re-

porting produce significant bottom line savings, and undoubtedly, improved relationships among all parties involved in this arena. Ombuds programs, bedside mediations and consensus-driven decisionmaking involving the medical staff and family of the patient, and other models all present tremendous opportunities to reform our current system. I am confident that the committee could obtain information and testimony from hospital administrators using these programs. The healthcare industry would benefit from broader experimentation with these models, and should be strongly urged to find and implement these programs and give them a chance to prove their efficacy.

Question 3. If a health court system was voluntary or opt-in, as you suggested, how could we ensure that a consistent standard of care was upheld across the board in the civil and health court system? How could an opt-in system address the issue of varying standards of care within the medical malpractice system?

Answer 3. A "health court" system, as I understand the proposals that are currently pending, would not provide for voluntary participation or even provide for a party to opt-in only after a dispute has arisen. I would like to clarify my testimony if I was understood to have suggested that participation was voluntary in some proposals. Mediation is a time-tested, equitable alternative to litigation, when it is voluntary and the fully informed choice to mediate occurs after the dispute arises. Likewise, arbitration is another available alternative to litigation when a fully informed injured party decides to use that dispute resolution method on a voluntary basis after a dispute have arisen.

We know, as a nation of laws, that providing justice is a difficult thing. Every day, in courts across our Nation, our system is being challenged to be more fair and more responsive to the problems of our day. The process for the opportunity to do that was built into the system in the beginning. It is self correcting, and its rules have had over two centuries of refinement. The "health courts" proposal does not demonstrate a better alternative to our existing court system, and it possesses none of the checks against abuse of process that are present in our courts.

Question 4. You have a great deal of experience with mediation and other forms of alternative dispute resolution. Based on that experience, you emphasize the importance of *voluntary* participation of parties. The consent of the injured patient must be truly informed, he or she must understand what rights are being given up and what benefits are being received in return. That can only take place after the injury has occurred.

Would you elaborate on this point, and explain why such truly voluntary participation is so important to the fairness and effectiveness of any alternative dispute resolution system for medical malpractice cases?

Answer 4. Our court system is designed to provide an even, fair process for resolving disputes. The most vulnerable may have their grievances against the most powerful heard in a forum that treats them as equals. The use of any alternative to that system must be considered very carefully, because the other alternatives lack the infrastructure of the court system and thereby present a greater opportunity for inconsistent and perhaps, unjust outcomes. ADR processes of mediation and arbitration are desirable when highly trained, highly skilled and highly experienced neutrals are in place.

The underlying principle of alternative dispute resolution is that these other methodologies may provide a more desirable process when their use can be shown to have a greater likelihood of meeting the needs of the disputants. And the array of reasons to opt for an ADR process, such as mediation, is extensive and often unique to the dispute. There may be urgency in resolving a case (i.e., to replace the earnings of an injured patient for a family; the injured patient is not going to survive; the practice which led to the injury must be halted). The injured patient may present unique needs that may be more meaningfully addressed in a cooperative forum, rather than an adversarial proceeding. Injured patients need professional advice about the pros and cons of each option. Most importantly, they must understand what they stand to gain and what they stand to lose with every forum.

The only way for an injured patient to make a meaningful choice of forums is to be fully knowledgeable of their needs and of which method provides the greatest opportunity to have their needs meaningfully addressed. They should have ethical counsel to help them make the choice, to represent them in the process, and to work with them to achieve the desired outcome. Proponents of ADR are committed to the promise of these methods as a component of our legal system only when all of the safeguards of knowledge and understanding are in place. For us to do any less would be unfair, unjust, and (if I may say so) un-American.

Question 5. Proponents of replacing the right to a jury trial with an administrative system or with health courts often point to workers' compensation laws as a model. You state in your testimony that an administrative compensation system would not work for medical injuries because it would not be a true no fault system. Injured patients would lose the right to a jury trial, but still need to prove that the doctor did something wrong. Please elaborate on the reasons that workers' compensation is not an appropriate model for medical injury cases.

Answer 5. As I stated in my testimony at the hearing, Workers' Compensation was designed to provide injured workers a process to compensate them for injuries that take place in the workplace. In exchange for their access to the court system, workers are guaranteed a certain award based on the injuries they suffered on the job.

"Health courts" are unlike the Workers' Compensation system in that, under a "health court" proposal, 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. Thus, under 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.

Question 6. Would you describe the type of voluntary mediation process that you believe would be appropriate for medical malpractice cases? Are you familiar with mediation programs in place today that you believe are performing well?

Answer 6. Medical malpractice mediation is proving to be a viable alternative to litigation in appropriate cases. Mediation is generally easier to schedule and complete than litigation.

Mediation is by definition voluntary, and often provides the opportunity to custom-design an agreement that meets the unique needs of the disputant. The opportunity to reduce adversarial behavior and promote cooperation is always present. Mediation is forward looking, while litigation and fact finding tend to be less so. Mediated agreements are usually easier to enforce, because the parties have entered into them voluntarily. There are many more reasons that mediation, when used appropriately and practiced ethically, is a very desirable component of the legal system for many types of cases, including some medical malpractice cases.

The program at Rush Hospital in Chicago is a wonderful demonstration of successful, appropriate and ethical use of mediation. Mediations are often facilitated by a team of co-mediators, and these co-mediators are selected because they have been lawyers or judges in the medical malpractice area. The process is entirely voluntary and great care is taken to assure that the sessions take place in a cooperative, non-adversarial setting. Appropriate case analysis is completed and conferences of the representatives of the parties are held. A meaningful assessment of discovery takes place, and ample opportunity for counsel and extended sessions are part of the program. This model has proven successful in my home city, a city that took a step toward mediation thoughtfully and carefully. It has been widely respected. It is one of many successful programs across the country.

RESPONSE TO QUESTIONS OF THE COMMITTEE BY NEIL VIDMAR

Question 1. Dr. Vidmar, thank you for balancing the discussion today with your broad testimony supporting the current medical litigation system. You point out on page 6 of your written testimony that only 1 of 7 injured patients sues, and therefore receives compensation for injury. Isn't this a failure of the current system to provide fair compensation and to truly address the needs of patients?

Answer 1. The issue is complicated and many people want to simplify it. The question assumes that patients who are negligently injured from negligence are aware of the negligence or, if they are aware, they want to sue their doctor, or that they desire or need compensation.

Many patients may be unaware that their injury is a result of negligence. The studies of injuries in the Harvard study and others that have followed, including the recent *New England Journal of Medicine* study by Studdert et al., are based on reviews of completed hospital records. The researchers have the advantage of hindsight that was not necessarily available to the injured patient. The data provide no indication that the patients were aware of the negligence.

Most injuries occur in hospital settings. Patients enter hospitals because they are sick or need an operation. Often, it is difficult for the patients to determine if the

injury or illness they experience following negligent medical treatment is the result of the condition for which they sought treatment or negligence. In one of the very first cases I studied when I began my research on medical malpractice a woman with cancer died in the hospital. Her husband assumed it was a natural result of her cancer. However, 2 months later when he received documents bearing on his wife's death he discovered that the hospital pathologist had concluded that her death was the result of negligent medical treatment. He was not told of the pathology report by the hospital. Thus, what the medical profession calls "co-morbidity," often prevents the patient from recognizing that negligence may have been involved in the treatment.

As far as I know we do not have data on the frequency and degree to which patients are aware that negligence has occurred in their case. I do draw attention to research by Professor Lori Andrews, *Studying Medical Error In Situ: Implications for Malpractice Law and Policy* 54 DePaul Law Review 357 (2005). She documented quite strikingly that many medical errors do not even appear in the hospital records. This is additional evidence bearing on patient ignorance of negligence. In short, if the patient ascribes post-medical condition to the "presenting" (prior to treatment) illness or injury, there is no reason to enter a complaint or seek the advice of a lawyer. *The failure to claim for this reason would also be true under a health court scheme.*

Still another reason that people do not make claims is that even when they learn that a negligent error has occurred, they are willing to accept that any negligence was not malicious on the part of the healthcare provider, e.g., "We all make mistakes and the doctors were trying." I think that this factor probably additionally suppresses claiming rates. My mother was suffering from dementia due to advanced age and was living in a nursing home. She suffered a ruptured bowel and was at death's door. A surgeon in St. Francis Hospital in Litchfield, Illinois performed surgery and saved her life. My sister and brother and I had agreed to a post-surgery "do not resuscitate order" on her medical chart. (Prior to her dementia she had quietly said several times to each of us that this would be her wish). Suppose she had died after the surgery and we learned that some form of negligence had occurred. I can say with almost 100 percent certainty that I and my siblings would not have sued. The doctor and the hospital were doing their best.

Too often patients and American people are characterized as greedy and willing to sue on any occasion. Research evidence indicates the contrary. Professor David Engle, *The Ovenbird's Song: Insiders, Outsiders and Personal Injuries in an American Community*, 18 Law & Society Review 551 (1984) documented this reluctance to make claims in what many scholars consider a classic study of disputing behavior. May and Stengle, *Who Sues Their Doctors? How Patients Handle Medical Grievances*, 24 Law & Society Review 105 (1990) found similar results in a study bearing specifically on medical errors. People have high regard for their doctors and are willing to accept many errors and forgive. The findings have been supported by other studies. Indeed, I have myself published peer-reviewed articles bearing on this reluctance to sue. I think Richard Boothman's testimony before this committee strongly supports my position on this issue as well. *The failure to claim for this reason would be true under a health court system as well.*

Still another reason for not seeking compensation is that some injured patients may have alternative sources of support. These include private health insurance or Medicare or Medicaid or income support from employers or welfare. There is no need to sue for health costs or lost income. *The failure to claim for this reason would be true under a health court system as well.*

Now, it is true that the present tort system is expensive. Some people are possibly kept out of the tort system simply because a lawyer cannot afford to litigate the case. Professor Herbert Kritzer's research on plaintiff lawyers, Herbert Kritzer, Risks, Reputations and Rewards: Contingency Fee Legal Practice in the United States (2004), clearly shows how carefully plaintiff lawyers screen cases because they cannot afford to take on a case that is going to cost too much to litigate or has a poor likelihood of success or that the potential returns are too small. Plaintiff lawyers are sometimes castigated for this, but you do not need a business degree to understand that taking on cases in such circumstances would quickly put a lawyer into bankruptcy. On the other hand, some of the problem of the costs lies with defendants who obstruct and fight cases rather than acknowledge negligence. I think Ms. Sheridan made an important point in her oral testimony before this committee. In her son's first trial the "junk science" was brought by the defense, not the plaintiff. This is consistent with my observation of malpractice cases over the past 20 years. I also note that *because the proposed health courts are not no-fault courts and require instead that a patient prove negligence the problems of transaction costs will deter lawyers taking cases for the same reasons, perhaps even more*

so if the health courts are subject to bias in favor of healthcare providers as many of us fear.

Question 2. As you know, it often takes several years to achieve a verdict or a settlement in medical malpractice cases. The personal pain and suffering related to such prolonged solutions, let alone the cost seems inappropriate and may provide compensation much too late after an injury. Isn't this a sign of the failure of the current system to be efficient or effective? Have you had a chance to read the two Institute of Medicine reports on patient safety and quality? Do you see the concerns raised and approaches now being taken to address these issues as being less effective than the current litigation approach?

Answer 2. This question poses a "compared to which alternatives" issue for me.

My own research indicates an average of 3 to 6 years to resolve medical malpractice cases. I have written about the litigation process in my book, Medical Malpractice and the American Jury (1995), and in a recent essay in 38 Loyola of Los Angeles Law Review 1217 (2005). My insights on this issue were especially aided when I had access to a sample of three different liability insurers' closed claim files. I supplemented the file data with interviews with plaintiff and defense lawyers and insurance adjusters.

Non-lawyers (and some academic lawyers) assume that the process of obtaining evidence bearing on negligence when it is contested by the defense is something that can be accomplished in a matter of weeks. The reality is different. Records have to be obtained, but health providers do not receive a letter from a plaintiff's lawyer and send the records out in the next day's mail. Sometimes they resist until a lawsuit is filed and they are compelled to produce the records. Even those providers who do agree to provide records first consult with their lawyers and department head and the personnel and obtain opinions on both medical and legal issues, etc. It may be weeks or months before the records are sent to the plaintiff's lawyer. Then the plaintiff's lawyer must conduct an in-house screen of the records before attempting to find a medical expert to review the files. This may take some time because the lawyer has to do his or her own research on the topic before seeking an expert. Then, the plaintiff's expert must find time in her busy schedule to write an evaluation and send it to the plaintiff's lawyer. Then the lawyer must write the pleadings and wait for a reply from the defendant—or defendants, each of whom may have their own lawyer. Most medical malpractice cases initially have multiple defendants because it is not clear at the early stages of investigation that might bear responsibility. Then the defendants have to seek their own experts to review the records—more weeks or months pass. Then lawyers for both sides have to arrange their busy schedules—they each have a portfolio of cases and perhaps upcoming trials in other cases—and fly to some distant location to depose the experts. And so on, and so on.

If the process of evidence discovery is to be fair health courts will encounter the same problems. There is a suggestion that the health court will provide the experts. This too will take time. Moreover, the proposals seem to indicate that the plaintiff and the defendants can have their own independent expert witnesses. It is possible that health courts could actually increase transaction time and costs.

Question 3. In your written statement you state that only 1 out of 7 patients who actually "suffered a negligent injury" files a claim. As it stands today, some meritorious claims are kept out of the system altogether because of the skyrocketing costs of the current system. In your opinion, how might patients with more minimal injuries caused by possible physician negligence benefit if their cases were heard in health courts?

Answer 3. First of all, my own research with Florida closed claims data submitted by liability insurers, Vidmar et al. 54 DePaul Law Review 315 at 352 (2005) indicated that in Florida transaction costs, when adjusted for inflation, had not increased over a 14-year period: "The mean transaction cost for paid claims from 1990 to 1993 was $40,853, compared to $39,158 for the 2000–2003 period, a difference that is not statistically significant." Our data were derived from public records and I invite anyone to check the figures. While the data pertain only to Florida, claims about increasing costs in that State are contradicted by the insurer's own data. A study of similar data from Texas, Charles Black et al. *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988–2002* Journal of Empirical Legal Studies (2005) yielded similar findings. I suggest that some of the claims made about "skyrocketing costs" need to be treated with some skepticism.

I am strongly in favor of resolving cases on a voluntary basis through negotiation or mediation. The Michigan program discussed by Richard Boothman and similar programs are going a long way to fairly and efficiently address problems with more

minimal injuries. As I have suggested in preceding questions, I have doubts about both the fairness and presumed greater efficiency of the proposed health courts.

Question 4. For less severe injuries, especially, might a schedule of damages send a more consistent message to physicians regarding the accepted and expected standards of care?

Answer 4. Truly, I do not see how a schedule of damages could—or should—have an effect on physician care. I cannot believe—I refuse to believe—that physicians are influenced in their caregiving by the remote prospect of potential damage awards. I do not see how a connection can be made between schedules of payments and medical care.

I am not a physician, but as an educated layperson I believe that the solution to care—and avoidance of medical error—lies in better understanding of the sources of error and how to prevent error. I have recently read the annual reports of the Pennsylvania Safety Reporting Commission established by the Pennsylvania Safety Authority. While in its infancy I believe this endeavor begins to show the way to better standards of care.

Question 5. Based on your own substantial research and numerous other studies of jury verdicts that you have reviewed, you state in your written testimony that most juries decide medical malpractice cases based on legal merit, not sympathy for the victim or the perception that the defendant is a deep pocket. Jurors are able to sort through the competing testimony of dueling experts. You also point out that the extensive case reviews have shown that jury determinations on liability closely track the conclusions of objective medical experts. In other words, juries are good fact finders.

This is an extremely important finding because it effectively rebuts negative stereotypes of the jury system that we often hear. Would you elaborate on the basis for your conclusion that most juries reach accurate verdicts consistent with the evidence?

Answer 5. I am delighted to respond to this question. This summer I am finishing a book on the subject, *American Juries*, with my colleague Valerie Hans.

Underlying most of the claims about the tort system for medical malpractice cases are claims that juries are the main problem. They are characterized as incompetent, anti-doctor, prone to sympathies for injured parties rather than legal facts, etc. As just one of many, many examples I refer to a statement made by the American Medical Association before this very committee on February 11, 2003:

> "The primary cause of the growing liability crisis is the unrestrained escalation in jury awards that are a part of a legal system that in many States is simply out of control."

I have been conducting empirical research on civil and criminal juries since for more than three and a half decades. Many colleagues have as well. There are literally hundreds of studies using different methodologies and published in peer-reviewed scientific journals. Based on this research, here is my conclusion that I will state in an intemperate way:

> The many thousands of American citizens who have honorably served on civil juries should ask a court to certify them as a class and file a class-action lawsuit for defamation of character. The American Medical Association and the National Chamber of Commerce can be named as the lead defendants, along with a host of others.

I suspect that no Senator or Congressman would dare publicly call his or her constituents "incompetent," "irresponsible," "rapacious," "gullible" and all of the other terms and phrases used to characterize juries. Yet, these very same constituents are the persons who are conscripted as jurors and comprise the juries that are so vilified in testimony before legislatures, in testimony before legislators, and occasionally by legislators themselves.

With respect to medical malpractice juries I will summarize what I offered in my written testimony. Empirical evidence by many researchers indicates that doctors win between 75 and 80 percent of jury trials. At minimum this is some pretty good indirect evidence that juries are not biased against doctors. Research also shows that when jury verdicts on liability are compared with the ratings of medical experts on whether negligence occurred there is a very high correspondence. When severity of injury and economic losses are taken into account, jury damage awards are, on the whole, very reasonable. Trial judges who sit with juries on a daily basis and hear the same evidence—and who are thus in a better position to judge jury performance than anyone—are overwhelmingly supportive of juries.

Question 6. You also point out that studies of damage awards show that "plaintiffs with the most severe injuries appear to be at the highest risk for inadequate compensation." Damage caps affect primarily the most severely injured patients, such as those with paralysis or brain injuries, because they are the only victims who would be likely to receive an award above the level of the cap. They are the last ones whose compensation should be arbitrarily limited. Would you explain what the research shows about the impact of caps?

Answer 6. I have reviewed this literature in several sources, e.g., 38 Loyola of Los Angeles Law Review 1217 (2005). Here are the basic findings: Research on the effectiveness of caps in reducing medical malpractice premiums lends, at best, equivocal support to the argument that they are effective.

A United States Government Accounting Office (GAO) report in 2003 showed that States with caps on medical malpractice damages tended to have lower premiums for doctors and that rate increases were lower in States with caps. However, the report also concluded that it is not possible to show a direct link between caps and premiums because there are other factors that distinguish States with and without caps. Moreover, some States without caps had the lowest premiums of all. Importantly, the GAO concluded that there are *no data to establish the proposition that damage caps have an effect on the number of malpractice claims, losses by medical insurers, litigation expenses, or the rates charged doctors for insurance.*

In the same year, Weiss Ratings, Inc., a highly respected insurance rating company, also concluded that caps do not have an effect on the insurance premiums that they charge doctors. Indeed, Weiss found that in comparison to States without caps, States with caps had greater increases in median annual insurance premiums for practices involving internal medicine, general surgery and obstetrics-gynecology.

An analysis of statistical information for 2003 by the Kaiser Family Foundation, another highly respected organization dedicated to healthcare, showed that the number of paid claims per 1,000 active physicians was unrelated to whether a State had caps on pain and suffering.

Professor Catherine Sharkey analyzed medical malpractice jury verdicts from 22 States for the years 1992, 1996 and 2001 that were collected by the National Center for State Courts. Sharkey found no statistically significant relationship between the presence or absence of caps and compensatory damages in jury verdicts and trial court judgments.

Kessler, Sage and Becker studied the impact of malpractice reforms on the number of physicians in States with malpractice reforms and States without such reforms. The study did not specifically separate caps from other reforms. Overall, a combination of tort reforms was associated with a slightly greater number of physicians. The study did not examine the effects of reforms on malpractice premiums or on the frequency of claims or the amounts of awards. The authors of the study acknowledged that malpractice climate is one of many determinants of the physician workforce and that the reforms they studied had only a "modest impact" on the number of physicians. Moreover, the authors acknowledged that there were possible alternative explanations for their findings.

I analyzed a sample of Illinois jury verdicts that provided breakdowns of the verdicts into their specific components or elements, including pain and suffering. The analysis showed that a $500,000 cap on pain and suffering would functionally affect very few cases.

The Wisconsin U.S. Supreme Court decision analyzed a substantial body or empirical research bearing on caps with specific reference to the State of Wisconsin. The Court drew a number of conclusions that included:

> "Based on the available evidence from nearly 10 years of experience with caps on non-economic damages in medical malpractice cases in Wisconsin and other States, it is not reasonable to conclude that the $350,000 cap has its intended effect of reducing medical malpractice insurance premiums."
>
> "The available evidence indicates that healthcare providers do not decide to practice in a particular State based on the State's cap on non-economic damages."
>
> "We agree with those courts that have determined that the correlation between caps on non-economic damages and the reduction of medical malpractice premiums or overall healthcare costs is at best indirect, weak and remote."

In 2003, GE Medical Protective Company, the Nation's largest medical malpractice insurer, reported to the Texas Department of Insurance as follows: "Non-economic damages are a small percentage of total losses paid. Capping non-economic damages will show loss savings of 1.0 percent."

The company also said that a provision in Texas law allowing for periodic payments of awards would provide a savings of only 1.1 percent. Medical Protective eventually raised the rates on its physician policyholders.

In California in 2003, despite the cap of $250,000, GE Medical Mutual sought an increase of 29.2 percent in liability insurance premiums. Thus, the cap did not prevent a major increase in liability insurance rates.

Question 7. The proposals to impose what the Enzi bill calls a "defined compensation schedule" would also deny the fact finder the ability to consider the full impact of the injury on the victims' life. It would set an arbitrary limit on compensation for a particular type of injury. Wouldn't this have an impact similar to damage caps, reducing the amount of compensation that the most severely injured patients could receive?

Answer 7. Yes. In addition to serious questions about who is to set these standards, there are questions about whether the amount would be sufficient in specific cases. My own research on Florida cases that were settled without a lawsuit even being filed offered some unique insights into the variability of the actual economic losses. Many of the losses can only be described as catastrophic. The files contained information on "structured settlements," that is, money that was invested to ensure the economic well-being of the negligently injured patient and often their dependents. I reported some of these data in a table in my written testimony on June 22, 2006 but it is useful to reproduce that table again. The data show very clearly the great variability in the amount that the defendants—who acknowledged negligence—paid badly injured patients as well as how much was believed to be necessary to keep the patient and any dependents economically independent. I think that this single table is the equivalent of a picture being worth a thousand words. I suggest readers examine this picture carefully. A careful examination will raise questions about how any schedule can be designed to provide individual justice for patients such as these. Moreover, the most badly harmed individuals will be treated most unjustly.

Settle Year	Case	Sex	Age	Injury	Settlement	Structured
1991	BMH	M	0	Spastic quad; cerebral palsyriplegia.	$1,887,044	$1 million cash plus $887,044 annuity yielding an expected total payment to child of $13,855,826.
1992	WCD	M	1	Severe brain damage, blind, deaf, immobile.	$1,000,000	$640,000 cash plus $540,000 annuity yielding $2,557/month for child plaintiff.
1992	UMS	F	0	Severe mental, emotional impairment.	$3,000,000	No details except an estimate that the annuity would yield $5,914,774.
1993	CRH	F	2	Severe cerebral palsy secondary to hypoxia.	$6,000,000	$4,922,115 cash; plus $1,077,885 present value for structured trust expected to yield $3,179,273 (Note medical expenses incurred to date of the settlement = $989,164).
1993	TGP	M	43	Renal cell carcinoma.	$2,000,000	$1,389,542 cash plus $610,459 for structured settlement for 3 surviving minor children.
1993	AHP	F	0	Paraplegia	$3,750,000	$2,300,000 plus $1,450,000 present value for annuity.
1994	AR	M	0	Profound brain damage.	$1,000,000	$440,178 cash plus $559,822 annuity yielding a total of $2,912,000.
1994	GBP	F	39	Vegetative state, non-reversible.	$3,000,000	$1,500,000 cash plus $1,500,000 annuity expected to yield an expected payment to the plaintiff of $8,783,183 for plaintiff and four minor dependants.
1995	FHH	M	25	Spinal cord injury	$2,647,617	$1,156,000 cash plus $1,491,000 for structured annuity expected to yield $5,291,937.
1995	CHM	M	0	Canavan's Disease (degenerartive disorder of central nervous system).	$2,383,900	$1,092,209 cash plus $1,291,691 for annuity yielding lump sum payments at 5 and 10 years totaling $2,000,000.

Settle Year	Case	Sex	Age	Injury	Settlement	Structured
1995	HBM	F	32	Coma	$7,250,000	Cash and annuity cost unknown but annuity estimated to yield $16,129,528.
1996	RLC	UK	UK	Death	$1,500,000	$1,429,808 cash plus $70,192 for annuity yielding a total payment to plaintiff's family of $1,422,239.
1996	CPC	M	0	Required resuscitation; neurological damage.	$2,500,000	$1,187,940 cash plus $1,312,060 for annuity, yielding $3,307,824 for the child.
1996	ORH	F	0	Brain damage	$7,300,000	$5,100,000 cash paid on behalf of four defendants plus $2,200,000 for an annuity. Total yield of annuity unknown.
1996	GMI	F	0	Severe brain damage.	$6,379,322	$5,529,332 cash plus $850,000 annuity yielding $8,066/mo for life of the child.
1996	DCH	M	0	Cerebral palsy	$3,000,000	$2,600,000 cash plus $800,000 annuity expected to yield $13,783,483 over the child's life.
1996	CKR	F	30	Brain herniation	$3,000,000	$1,800,000 cash plus $1,200,000 from three insurance carriers for an annuity expected to yield a total of $7,816,824.
1996	FHA	M	0	Cerebral vasculitis and bilateral thalamic infarcts.	$6,500,000	$4,500,359 cash plus $1,999,641 for an annuity yielding $7,855/mo for life plus periodic cash payments graduating from $50,000/yr to balloon at 25 years to $250,000.
1997	SVC	M	52	Brain damage	$1,000,000	$582,935 cash plus $417,065 for annuity, yielding expected total of $1,572,935.
1997	HCP	M	49	Death	$5,000,000	$4,000,000 cash plus $1,000,000 annuity yielding projected $3,976,503 for decedent's minor daughter.
1997	KCM	F	37	Paraplegia and cauda equina syndrome (spinal cord ends).	$3,520,160	$1,845,160 cash plus $1,675,000 to two annuity companies yielding an expected total of $8,157,597.
1998	GJL	F	52	Paraplegia	$1,000,000	$500,000 cash plus $500,000 annuity starting at $2,500 per month and then adjusted for inflation.
1998	COR	M	56	Death	$1,000,000	Payout of approximately $2,000 per month over 35 years.
1997	LMG	M	39	Death	$1,250,000	$553,359.60 cash plus annuities purchased at $354,4560: $111,048.20 and $111,048.20 yielding a total of $1,129,912.
1998	UM	F	56	Right ankle, left below knee amputation.	$1,625,000	$700,000 cash and annuity providing $4,000 per month for 5 years and $1,000 per month for 7 years.
1998	GSHI	M	62	Quadriparesis, neurogenic bladder.	$1,449,032	$675,000 cash and annuity providing $9,750 per month for 5 years or life.
1998	UCH	M	2	Profound brain damage.	$5,000,000	$2,500 per month, increase 3 percent per year. 20 years guaranteed, plus life.
1997	CKMC	F	37	Paraplegia and cauda equina syndrome (spinal cord ends).	$3,520,000	Cash payment of $1,845,160 and two annuities purchased with present value of $1,675,000: total payments estimated at $8,157,597.
1999	SPGH	F	0	Severe cognitive delays, requires occupational therapy, physical therapy, speech therapy.	$5,500,000	Total annuities yielding $12,754.31 per month.
1999	PRMC	F	21	Death	$2,250,000	Cash of $1,809,709 plus annuity for surviving child purchased at $440,291.

Settle Year	Case	Sex	Age	Injury	Settlement	Structured
1999	PRMC	F ..	1 ..	Hemorrhagic periventricular leukomalacia, hypoxic ischemic injury resulting in motor development delay, cognitive defects.	$3,300,000	Cash of $907,829 plus annuity purchased for $2,392,171 for life care of child.

There is another important matter regarding the proposed schedules. I acknowledge that Professor Studdert's Draft Proposal on his proposed health court that was appended to his testimony is a work in progress. I do not want to be unfair in that regard. Yet, I took a close look at that proposal regarding how damage award schedules are currently being considered. I contend that the "current recommendations" of his *Design of a "Health Court " System* on page 3 helps to illustrate the problems with schedules.

First consider economic damages: "Economic damages will be paid in full." Ask any practicing plaintiff or defense lawyer how contentious economic losses can be. Two experts will offer estimates of the cost of future medical care that vary by literally millions of dollars. Similar problems attend with income loss, especially if the injured party has a business that one expert will estimate enormous growth potential and the other expert will estimate stagnation in sales leading to no growth. There is no truly right answer on economic losses. That is why for more than 200 years we have relied on a group of citizens to apply their logic and local community standards to make the decision. Jury decisions are not about absolute truth because there is no absolute truth. The only criterion is fairness.

However, I find the most problematic issue to be with regard to so-called "noneconomic" damages. On page 3 the Studdert proposal states: "Noneconomic damages will be paid according to a schedule tied to severity of injury and **based on decision science research about utility losses and public deliberation about reasonable compensation.**" (Bold added for emphasis).

I am not sure exactly what is meant by "decision science" although I am a trained social scientist. Is the proposal referring to those economic theory studies that ask people in the abstract how much money they would require to allow someone to amputate one of their arms or take away their eyesight? With all due respect to some economic scholars, I think the general public would find this criterion very unacceptable!

But what about "public deliberation about reasonable compensation" that is another criterion set out on page 3? Isn't deliberation what juries already do? Or does public deliberation refer to town hall meetings with votes about appropriate ranges or possibly statewide referenda? If either, how do you get an informed public decision when these votes will be made in the abstract?

In contrast under our present system, juries see the patient, hear about the suffering and hear from experts about the future health and employment prospects of the specific individual. They make informed decisions based on the individual case.

The Studdert draft also considers basing the schedules on "past jury awards." Which past awards? Is not the aim of health court proponents to avoid jury awards altogether?

Schedules deny individual justice. They hurt the persons most severely injured. They are inconsistent with American law and American tradition. They are unfair.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

On behalf of the American College of Obstetricians and Gynecologists (ACOG), representing 49,000 physicians and partners in women's healthcare, thank you for holding this important hearing on alternatives to the current medical liability system.

America's broken medical liability system fails both injured patients and their physicians. Many patients with legitimate injury claims never enter the civil justice system, while as many as half of the claims that do enter the system are without merit. The system fails to do what it is supposed to do: accurately and efficiently identify cases of negligence, fairly compensate injured patients, and promote patient

safety. The current medical liability system is random, unpredictable and ineffective.

Obstetrician-gynecologists pay the price through the meteoric rise in medical liability premiums that is threatening women's access to healthcare. Good doctors who have been so important to their patients and their communities are dropping obstetrics, ending their surgical practice, or closing their medical practices completely. Medical students who love the idea of ushering tiny lives into this world are turning away from the litigious culture that surrounds ob-gyn. And America's women are left asking, "Who will deliver my baby?"

ACOG strongly supports comprehensive Federal legislation to reform the system, including placing a reasonable cap on non-economic damage awards, as has been accomplished in California and Texas. We'll continue working toward this goal until it's won.

At the same time, we believe there is enormous benefit in exploring promising alternatives that would more fundamentally fix America's broken liability system, including healthcare courts and early offers demonstration programs, as S. 1337 would provide. ACOG has supported healthcare courts and early offers for many years. These alternatives would help guarantee that injured patients are fairly, quickly, and fully compensated for their economic and noneconomic damages. These alternatives take injury claims out of the adversarial tort system where facts are often poorly understood, and put them into the hands of experts whose goals are fairness and patient safety.

OUR PRESENT MEDICAL JUSTICE SYSTEM FAILS ITS OWN OBJECTIVES

Unable to Define Medical Negligence

In the United States today, patients harmed by medical care generally have one legal option to get compensation for their injuries: they can bring a tort claim alleging medical negligence in a State civil court system.

To prove negligence, in general the patient must show that his or her physician failed to act reasonably under the circumstances, i.e., to provide a reasonable standard of medical care as ordinarily provided in the specialty, resulting in harm to the patient.[1]

Experts say that all parties to medical litigation—patients, doctors, insurers, and attorneys for both sides—can be unclear as to what medical negligence really means and what's required as proof.[2] When it comes to medical care, civil courts do a poor job of distinguishing between negligence and non-negligence, or between poor and good care.[3]

Many injured patients do not have access to civil courts. The landmark Harvard Medical Practice study of 1991 estimated that while 5–6 percent of patients are harmed by negligence each year, fewer than 2 percent ever file a claim.[4] The elderly and the poor are disproportionately left out.[5] And only 1 in 14 people with a serious injury resulting in a disability of 6 months or more is ever compensated.

Conversely, the civil justice system also fails to adequately screen out patients who don't belong there. Studies from 1991 to 2006 find that from 37 percent to over 50 percent of claims filed each year have no merit, and from 13 percent to 25 percent of cases filed where no negligence occurred still receive compensation. Cases with no merit also bring other costs to our justice system: a 2006 study of medical liability cases found that baseless claims accounted for 21 percent of administrative costs and 16 percent of total liability system costs.[6]

That's the mark of a system that fails to do what it's supposed to do: accurately and efficiently identify cases of negligence, fairly compensate injured patients, and promote patient safety.

For patients injured by negligence, the civil justice system fails to provide **fair and timely compensation**. For physicians, it fails to provide guideposts for behavior, **be a fair and effective deterrent** against substandard care or accurately distinguish between negligent and non-negligent care. For insurers, the unpredictability and randomness of the current system creates **an unstable medical liability insurance market** and skyrocketing premiums.[7]

Doesn't Help Patients

The current tort system is not easy for patients to navigate. Medical liability cases are among the most unpredictable and complex to litigate, and proving fault can be difficult.[8]

The system is lengthy and expensive for patients. The average liability claim takes 3 to 5 years to resolve and attorney fees and court costs can be high.

Many attorneys take cases on a contingency fee basis, taking a percentage of any fees won, but this arrangement also has its limitations. Often the plaintiff has to

pay upfront to cover their attorney's out of pocket costs. The system eats away at any compensation eventually won. About 50 cents of each dollar in the liability system goes to attorneys' fees and costs.[6 9] And the arrangement makes attorneys more inclined to take particular types of cases and exclude others, favoring cases that promise large rewards or a plaintiff sympathetic to jurors.[10] Patients whose cases may be meritorious, but small-value, are often left out. Many injured patients don't meet the negligence standard at all.

Patient safety experts believe that most cases of patient injury in the U.S. healthcare system are not due to physician negligence, but to system errors in healthcare institutions. This can include the misreading of prescriptions by hospital staff, lost records, or poor communication between departments.[11] The tort system is a poor fit for evaluating, preventing, or compensating the nature of their injuries.

Patient Care is Harmed

Although physicians prevail in most claims, the litigation process can be lengthy, expensive, and psychologically draining. The average case against ob-gyns takes 4 years to resolve, with 13 percent of cases taking 7 or more years.[12] In 2006, it cost ob-gyns an average of $35,000 to defend a medical liability case, including claims that were later dismissed, and claims without physician error accounted for 13–16 percent of the liability system's total monetary costs.[6]

An estimated 13 percent to 25 percent of all cases not involving negligence still receive compensation.[6] Negligence is poorly understood, and the tort system reaches beyond negligence and awards malpractice damages even when there was no malpractice. In some cases, jurors may be trying to squeeze what are really systems errors into the physician negligence "box."

Some juries find fault even if no mistakes or wrong-doing occurred, but instead the cases involved bad, sometimes heart-breaking, outcomes.[14] Cerebral palsy cases (neurologically impaired infants) in particular are susceptible to this type of verdict. Research shows that less than 10 percent of neurological impairment cases are the result of events occurring in labor and, of these, the majority were not preventable.[15] Yet, these cases account for 1 in 3 obstetric-related claims and the median award for "medical negligence in childbirth" cases is $2.3 million.[12 16]

The negligence standard—the heart of the medical tort case—has become meaningless. For physicians, litigation has been divorced from the quality of care they provide and a source of increasing stress and frustration.

This leads to poorer patient-doctor communication, with doctors less willing to express anything that might be construed as an expression of "fault." It increases defensive medicine practices, as doctors perform unnecessary procedures, tests, or referrals to specialists, to lessen their chances of being sued.[17] Some estimates of defensive medicine costs run as high as $60–100 billion a year. Defensive medicine increases the cost of a healthcare system that now accounts for nearly one-sixth (16 percent) of the Nation's gross domestic product.[18 19]

Physicians have endured three crises in liability insurance rates in the last 25 years, with cyclical skyrocketing premiums. Physicians have trouble affording or even finding insurance, which results in a reduction in services, and hurts patients' access to care. According to a 2003 survey of ob-gyns, over 1 in 4 have reduced their number of obstetrics cases and 1 in 7 stopped practicing obstetrics altogether due to liability insurance concerns. The scenario is likely to continue unless something changes in the medical justice system.[12]

THE HEALTH COURT MODEL

Researchers at the Harvard School of Public Health are studying the successful use of health courts in other countries and have pinpointed some key reasons why specialized health tribunals may correct serious deficiencies inherent in our tort system.[20]

1. Health courts would be separate, distinct forums from the general civil courts, speeding up adjudication and reducing costs.

Specialized judicial courts exist within the State judicial court system, but hear only certain types of cases. *Family law, domestic violence, probate, or mental health courts* are examples of specialized State judicial courts. Specialized *tax*, *patent*, *and admiralty* courts are also found in Federal law.

Administrative courts or tribunals hear disputes before an administrative judge or officer, with a limited right of review in the regular court system. *Worker's compensation* cases are examples of administrative hearings.

Key benefits of this approach would be:

- faster adjudication of medical claims,
- lower costs of litigation,

- faster compensatory relief to injured patients,
- more accurate determination of negligence and/or fault,
- more expert consideration of science and clinical considerations, and
- improved patient safety.

2. Trained adjudicators would hear cases, setting clearer and more consistent standards than under the civil jury system.

A judge or administrative hearing officer trained to hear medical cases would resolve disputes with greater reliability and consistency than in cases decided by untrained judges or juries. In contrast to juries, trained adjudicators could issue opinions that define standards of care or set legal precedent.

Medical cases—involving scientific and ethical questions about disease, biology, and appropriate medical treatment—can be highly complex. The United States is nearly alone among developed nations in using mostly juries rather than expert judges to decide medical liability cases. In England, Canada, France, Germany and Japan, medical liability disputes are decided by judges, not civil juries.[22]

3. Judges would be guided by panels of neutral medical experts, using evidence-based standards of care.

The U.S. tort system needs impartial medical experts to guide decisionmakers on complex medical questions and on the issue of what is "reasonable care" under the circumstances: to establish what standards of medical care apply in a given situation, or, as is frequently the case in medicine, what factors would guide physician behavior when no clear standards exist.

Instead, plaintiffs and defendants in the United States today hire their own medical experts, so juries often hear conflicting testimony about the quality of care. All too often, plaintiffs' experts have no specific expertise in the medical issues related to the case, or even the area of medicine involved. In many European civil law systems, judges may examine or select medical experts or choose a panel of neutral experts for guidance.[23]

4. Damage awards would be more predictable, consistent and fair, through guidelines for compensating intangible factors.

The amount of damage awards in U.S. medical negligence cases are random and unpredictable.

Damage awards for economic damages, such as past and future medical costs or lost wages, are fairly predictable. These awards depend on the plaintiffs individual circumstances and do not depend on a plaintiff being a wage-earner: injured infants or housewives, for example, are eligible for economic damages based on loss of potential future earnings or their economic value to the family.

Noneconomic damages, awarded for intangible factors including pain and suffering, fluctuate wildly for similar injuries and contribute to the high cost of medical liability insurance. In approximately half of the States in the United States there is no limit on these awards.[7]

In contrast, under a worker's compensation model, noneconomic damages are based on a schedule of award amounts that reflect the severity of the injury or extent of incapacitation. Even with upper limits on these damages, the system gives adjudicators flexibility to adjust damages based on individual circumstances.

In countries that use a schedule of damages to set awards—such as Denmark, Sweden or Great Britain—the even-handedness of the approach seems to contribute to a greater public satisfaction with the medical justice system, in marked contrast to the situation in the United States.[24] [25]

HEALTH COURTS COULD ALSO IMPROVE PATIENT SAFETY

Any new system that corrected the inequities in our current medical justice system would be worth pursuing. But what if it could also help reduce health system errors and improve patient safety? Some proposals for health courts aim to achieve both goals.

A 2000 Institute of Medicine study estimated that thousands of medical errors occur each year in the U.S. healthcare system, most due to system errors rather than to physician negligence or malpractice. System errors can include miscommunication between hospital departments, loss of charts in hospitals, or misreading of prescription information. As our healthcare system becomes more complex, opportunities for error increase.[11]

Currently, the U.S. tort system and the patient safety movement "function in separate worlds."[26] In fact, our litigation system often thwarts systematic efforts to improve patient safety.

Fear of litigation shuts down communication between doctors and patients and between personnel within medical institutions. Open sharing of information and learn-

ing from mistakes reduce the risk of errors. The aviation industry, for example, reduced its rate of error by switching from a culture of individual blame to a culture of data-sharing on the cause of mistakes.[27]

Many patients want more openness as well. Surveys show that patients harmed by medical care are less likely to sue if the physician apologizes and shows a willingness to correct such action in the future. The "I'm Sorry" movement is an effort to allow physicians to apologize when things go wrong without the apology exposing the physician to increased liability.[28]

Under our current litigation system, institutions and physicians cannot learn from mistakes. Often records are sealed in settlements of medical claims, keeping information that might be helpful to preventing future harm off-limits, even within the same hospital or institution.

HELPING JUSTICE AND REDUCING ERRORS

Researchers at the Harvard School of Public Health have summarized a model that could help join a better patient compensation system to improved patient safety efforts.[20]

An **administrative health court process** would promote open communication and patient safety measures.

1. A patient files a claim at the **facility level**. This could encourage discussions, I'm Sorry efforts, mediation, or early offers of compensation. Facilities could also use claims to help track data on system safety.
2. **A Reviewing Panel** (a facility, insurer, or administrative panel) would determine if the injury is compensable, in which case it would make an offer. If non-compensable, the panel would explain why.
3. Patients dissatisfied with the panel's decision could pursue the case before an **Administrative Health Court** for a hearing.
4. Using a high standard of review, a judicial *Appellate Court* would hear any appeals from the Health Court decision.

The second idea, proposed in the Harvard Model and earlier Institute of Medicine proposals, is to use a lesser standard of evidence for patients to prove harm: the **avoidability or preventability** rule. Under this standard, used in the Scandinavian system, injured patients prove only that such an injury should not have happened under optimal medical care.[20]

This standard requires a patient to show more evidence of medical wrongdoing than under a strict liability test, but is a more flexible standard of evidence than the current negligence standard, which is poorly understood and often misapplied. Among its benefits, the avoidability or predictability rule is more likely to:

- Compensate patients harmed by mistakes or system errors;
- Correct the abuse and misuse of the negligence rule; and
- Remove the stigma and blame of the negligence label, often attached to individual doctors who acted appropriately and were not negligent.

The focus is less on assessing blame, and more on helping harmed patients. And the interests of physicians and patients would once again be united in a common goal—better patient care.

QUESTIONS REMAIN, BUT PILOT PROJECTS SHOULD GO FORWARD

The status quo has become intolerable for both doctors and patients. Pilot projects to study health courts would investigate a potentially better system and, at a minimum, provide helpful information in evaluating medical justice models. There is much to gain and little to lose in going forward.

Research and clinical trials are essential to the development of advances in medicine. Advances in our medical justice system are no less deserving of investigation. Pilot projects to evaluate the merit of health courts can only improve the status quo and should be put in place as early as possible. A good start to investigate this and other alternatives to the current medical liability system is the ACOG-endorsed bill S. 1337, The Fair and Reliable Medical Justice Act, which was introduced in June 2005 by Senator Michael Enzi (R-WY) and Sen. Max Baucus (D-MT). We applaud Senator Enzi's leadership on this important issue and we pledge to work with the Senate and House toward speedy passage of this bill.

The Nation cannot afford to postpone correcting its deeply flawed medical justice process. We must begin today.

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[Whereupon, at 12:42 p.m., the committee adjourned.]

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