

TESTIMONY BEFORE THE

SENATE COMMITTEE ON

HEALTH, EDUCATION, LABOR, AND PENSIONS

AT THE HEARING ENTITLED

“MEDICAL LIABILITY:

NEW IDEAS FOR MAKING THE SYSTEM WORK BETTER FOR PATIENTS.

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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 ten 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 health care 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 thirty 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 non-meritorious 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 towards 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% range.⁴ For many disability insurance schemes—public and private—it runs as low as 10-15%.

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 major a 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% 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 towards 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 a 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% of the system’s total direct costs.) Instead, major savings depend on reforms that reconfigure the entire process in ways that improve efficiency in handling reasonable claims for compensation.

2. Unpaid errors outnumber paid non-errors

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% 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% 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 health care 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 health care 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 decision making)
- Assessments of damages more accurate and reliable
- 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 alternative 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 non-adversarial structure, with an administrative decision-making 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 health care 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 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 thirty 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 health care 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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