

TESTIMONY OF
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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 United States 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 thirty 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, health care 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 United States Senate with the most direct jurisdiction over American health care 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 health care 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 health care delivery. Public expectations of health care 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 health care, 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. Health care 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, health care 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 health care quality. Administrative health courts might be established under the auspices of state agencies that regulate health care 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 health care 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 efforts, (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 health care 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 health care 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 twenty years ago, and now experiences the health care 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 health care system requires careful governance, including with respect to medical liability.

The successor report to *To Err Is Human* called upon the health care 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.