

Testimony of

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before the

United States Senate

*Committee on
Health, Education, Labor and Pensions*

Thursday, June 22, 2006

**“Medical Justice: Making the System Work Better
for Patients and Doctors”**

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 health care 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 twenty two 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 United States 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 health care 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 six month pre suit notice requirement;
- Created a two-tiered cap on non-economic 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

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

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 not 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.

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% said that the threat of litigation adversely impacted the satisfaction they derived from the practice of medicine;
- 98% perceived a difference in the University of Michigan's approach to malpractice claims after 2001;
- 98% fully approved of the approach;
- 55% 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% rated the University of Michigan "the best" and "among the best" health systems for transparency;

- 90% recognized a change in the University of Michigan Health Systems approach since 2001;
- 81% said that they had changed their approach to our Health System in response;
- 81% said their costs were lower;
- 71% admitted that when they settled cases with the University of Michigan, the settlement amount was less than anticipated;
- 86% agreed that the University of Michigan's transparency allowed them to make better decisions about the claims they chose to pursue, and
- 57% 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 plaintiffs' 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

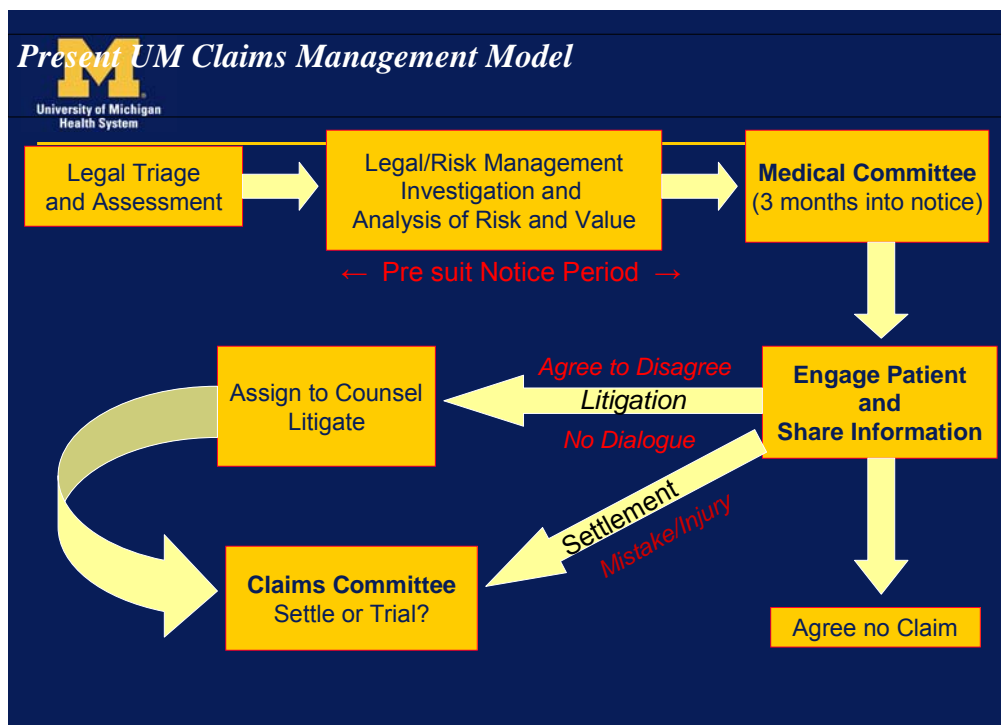
Flowing directly from this commitment is transparency. Decades of lawyers' admonitions not to talk about claims until the cases were resolved disappeared when we committed to acting in accordance with our conclusions about the reasonableness of our care. Concerns for compromising litigation virtually 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

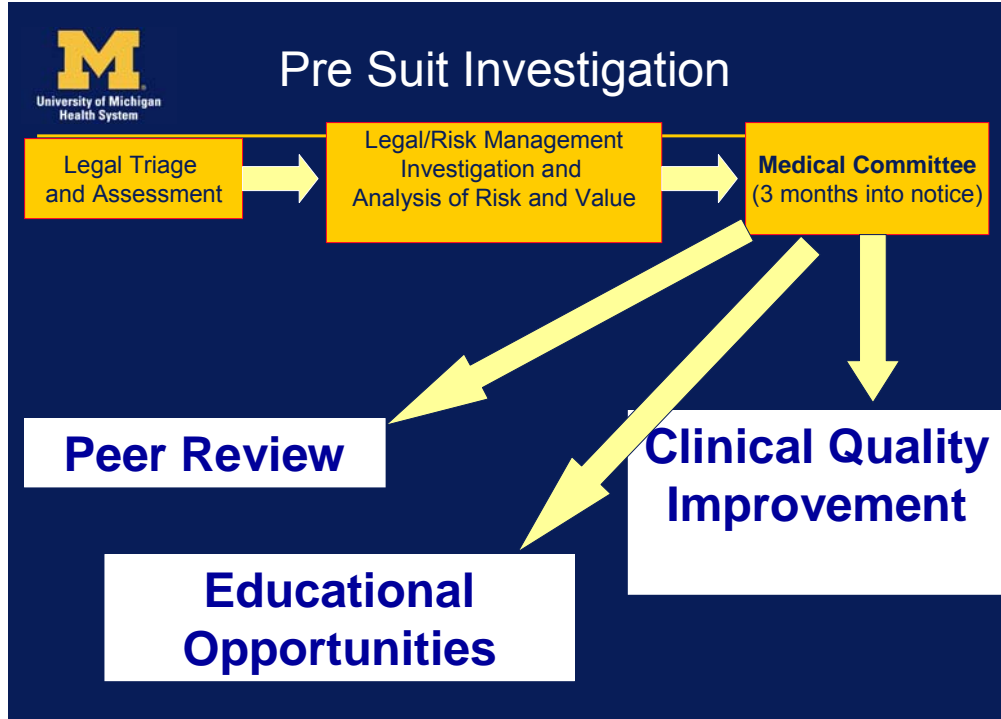
mistake. We did not want to defend a claim for years only to decide the claim warranted settlement and the patient and his lawyer obviously do not want to engage in expensive, time consuming and emotionally draining litigation only to lose the case. Discovery eventually leads to full disclosure anyway; 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 health care providers. Openly acknowledging that patient safety is at the heart of many patient complaints, our Chief of Staff, Skip Campbell, MD has undertaken bold initiatives in system-wide 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.

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

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. Health care 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 unreasonable 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 to 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 non-economic recovery. Caps on non economic 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 remittitur 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 ten 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 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.