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MEDICAL MALPRACTICE LIABILITY

HEARING

BEFORE THE

SUBCOMMITTEE ON MEDICARE AND LONG-TERM CARE

OF THE

COMMITTEE ON FINANCE UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

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MEDICAL MALPRACTICE LIABILITY

FRIDAY, OCTOBER 18, 1991

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE AND LONG-TERM CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:42 a.m., in room SD-215, Dirksen Senate Office Building, Hon. John D. Rockefeller IV (chairman of the subcommittee) presiding.

Also present: Senators Baucus, Daschle, and Durenberger.

[The press release announcing the hearing follows:]

[Press Release No. H-46, Oct. 11, 1991]

SUBCOMMITTEE TO EXAMINE MEDICAL MALPRACTICE LIABILITY; ROCKEFELLER CITES COSTLY IMPACT ON NATION'S HEALTH CARE COSTS

WASHINGTON, DC—Senator John D. Rockefeller IV, Chairman of the Finance Subcommittee on Medicare and Long-Term Care, Friday announced a Subcommittee hearing on medical malpractice liability issues.

The hearing will be at *10 a.m., Friday, October 18, 1991* in Room SD-215 of the Dirksen Senate Office Building.

Rockefeller (D., West Virginia) said the purpose of the hearing is to gather information about malpractice liability, rather than to discuss particular bills or proposals. The Subcommittee expects to examine specific proposals later.

"I am holding this hearing so that members of the Finance Committee can learn more about this extremely complex issue in order to help us figure out a way to integrate liability reform into comprehensive reform of our health care system," Rockefeller said.

"Currently it takes years to settle malpractice cases, and then only 22 cents of every dollar awarded even gets to those who were harmed. Some have estimated that defensive medicine adds about $15-$20 billion annually to this country's health care tab. Disaffected physicians are leaving practice, creating real access problems across the country," Rockefeller said.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA, CHAIRMAN OF THE SUBCOMMITTEE

Senator ROCKEFELLER. I want to apologize to my friend from Minnesota as well as my friend from New Mexico. I had this down as a 10:00 hearing and clearly arrived early. And as a courtesy to our first witness I would wonder if my friend from Minnesota and I might hold off our opening comments.

[The prepared statement of Senator Rockefeller appears in the appendix.]

STATEMENT OF HON. PETE V. DOMENICI, A U.S. SENATOR FROM NEW MEXICO

Senator DOMENICI. Thank you very much, Mr. Chairman. Because of that I will certainly try to be very brief. There are a lot of witnesses waiting for you here today. Pursuant to your instructions I submitted some rather detailed remarks and I have outlined them for myself. I would ask that the detailed remarks be made a part of the record.

Senator ROCKEFELLER. It will be done.

[The prepared statement appears in the appendix.]

Senator DOMENICI. I want to thank you, Mr. Chairman, and Senator Durenberger today for the leadership that you are showing by calling this important hearing. From what I can see, one of the big responsibilities we have with reference to the delivery of health care in this country is to try to control health care costs.

Frankly, we have tried all kinds of things related to our programs, the programs we have something to do with, but I think we forgot to do one thing. That is if we are going to control health care costs or at least be able to say we have done all we can, and we all know what a big price our country is paying for exorbitant health costs, I can report now that we used to use 11.9 percent of gross national product. I have more current numbers than that and it is already up to 12.3 percent. For those who were saying 12 percent wondering when it would get there, they did not have to wait very long. It is 12.3 percent of our gross national product now.

Just to put it into comparison in 1965 it was 5.9 percent of our GNP, dramatic. In 1989 we devoted over twice as much of our productive capacity to health care costs than the United Kingdom; 75 percent more than Japan; 40 percent more than what was West Germany. I do not know what it will be now, but then West Germany. And 35 percent more than Canada.

I do not have to relate those numbers to everyday economics. If one is interested in giving a real comparison that addresses competitiveness then just ask experts to relate that to the production of an automobile and ask how much health costs are in a Ford coming off the assembly line and how much its counterpart in Japan. When you do that you will find that it is about a little over two to one. So if it is $350 in Japan it is over $750 in the United States per automobile.

So I choose to talk about a lottery that is going on which I think is doing no good to anyone other than to make money for certain plaintiffs and even there they are getting the short end of the stick. The money is going to all the professionals involved in seeing to it that malpractice awards are rendered and collected on.

Our medical malpractice system as I see it is a large part of the health care system. Frankly, Senator, as I am sure there will be people to tell you, it is needed to keep the doctors on the straight and narrow. Absolute, utter baloney. We ought to set in motion a system that is more apt to keep the doctors in line. This malpractice system does not do that.

You can read the Harvard studies and you will note that very few malpractice cases are being filed. The average kind of case is not being filed and of the cases collected upon many, many of them

are not cases of negligence, but rather adverse events which cause a jury to be stimulated enough to say well we ought to give them an award.

So I call it a lottery. Very few hit the jackpot of big jury awards. Usually those with extremely competent lawyers or those who have suffered sensational injuries that draw sympathy from juries. I am not sure, I did not look at your witness list, but I think there is a chance before you finish today you will hear from some of those, some of those jackpot lawyers or those who represent them in the name of the consumer. That is not in the name of the consumer; it is in the name of the lawyers and the professionals that are collecting on the awards.

Frankly, Mr. Chairman, they cannot even convince the average folks of their lottery's good qualities. Just speak to any crowd of Americans and raise the issue of malpractice and medical malpractice liability and you will first get a kind of a hum. Then when you tell them it is robbing the American people they will cheer because they know it is not good for them. If it is not good for them, who is it good for?

So often someone can hit that jackpot and get a big jury award, even if the injuries that they are paying on are due to what I call an adverse event and not a physician's negligence. Malformed baby, that is the kind of adverse event that sometimes is negligence, most times not. But how can a jury fail to award something for the tremendous cost and care and suffering of a baby that is born malformed?

In response, physicians and other health care practice people and professionals are practicing defensive medicine. Now even if they do not know it will not benefit the patient they still do it because they want to create the perception, in case there are injuries, that they have provided the very best of care, or as I put it the type of care that defensive medicine is requiring.

They order unnecessary diagnostic tests, procedures that are unnecessary because they believe it is expected of them by the court system. And the court system is not the cure system; it is just what we call it, the court system. This unnecessary defensive medicine as well as extremely high medical malpractice insurance costs add billions of dollars to our health care bills every year with little or no additional benefit in terms of quality of health care.

You are aware that the recent Harvard study has documented, that there are tremendous inequities in the current malpractice system. It is stated in that study that 80 percent of the suits that are filed have no evidence of negligent care. But 97 percent of the persons injured due to negligent medical care never get compensated through the current litigation system.

Frankly, Mr. Chairman, that set of facts in and of itself is an indictment of the system and is sufficient to reform it and change it dramatically. Ninety-seven percent of the persons injured never get compensation and they will not under this system because they are average kind of cases. They are not the cases that are going to bring millions so nobody brings them. They are the cases that are worth a couple of hundred thousand or 50 thousand. Nobody is bringing them. The lawyers do not want them; they want the big jackpot lottery ones.

Now one might say to those who take the position that this system keeps the doctors honest, I submit that if you do a malpractice reform bill that is really meaningful, you can obviously help with the issue of incompetent doctors by seeing to it that as a condition of this legislation that the States set in motion a much more onerous and enforceable medical malpractice for the doctors themselves as to the practice of their healing arts.

That could be done as part and parcel of it and you do not have to listen to people who say you have to leave this in place or that doctors will not behave. You can force behavior changes by making the rules more enforceable out there in the market place. Because incidentally one of the biggest reasons the rule against doctors is not applied is courts again. It is doctors using the courts not to let professional malpractice be enforced against them. That ought to be fixed.

So from what I can tell, in 1980 the number of malpractice lawsuits per 100 physicians more than doubled from 3.2 to 7.4; 40 percent of all physicians can expect to be sued at some point in their careers; and 80 percent of all obstetricians will have a claim filed against them.

If the lawsuits under the current system have doubled I submit with the new influx of attorneys I do not see how it can help but double again to the detriment of many and to the profit of few.

The lottery system is very inefficient. You have said, Mr. Chairman, that only 22 percent of the malpractice insurance premiums actually reach injured patients; that 78 percent pays for lawyers and other administrative costs, another way of looking at whether the system works or not.

I am going to cite two quick stories and try to move on. In 1986 a medical malpractice suit in the City of Philadelphia. A woman alleged that a dye injected for a CAT scan triggered an allergic reaction and severe headaches. She claimed that the headaches impaired her job skills as a psychic with the power to read auras and conducts seances and predict the future. The jury deliberated 45 minutes and awarded her $1 million.

In March 1990, a trial in Florida, experts testified before a jury that a retired police officer suffered loss of memory, sight, deafness, loss of his left leg and arm due to negligence during back surgery, award $2.5 million. One year later he was seen boarding his brand new 46-foot yacht, driving to his home in the Florida Keys and carrying luggage up the stairs.

So it is no wonder that malpractice insurance premiums have gone through the roof. In the 1980's the malpractice premium increased at an average annual rate of 15.1 percent, outpacing the average rate of inflation in the overall system.

Obstetricians in the State of Florida, Mr. Chairman, we understand pay $150,000 in malpractice insurance premiums. In Michigan they pay $134,000 a year. These enormous premiums are passed on to the mothers who get prenatal care and delivery care if, in fact, obstetricians stay in their part of our respective States and continue to practice obstetrics.

You know that a number of obstetricians, especially in rural areas, are leaving the practice. It fell by 20 percent in 5 years because of the high cost of practice or concerns about being sued.

Now I just want to close with two remarks. One, I am sure for those who want to perpetuate the past they are going to tell this committee that it is the insurance company's fault. They are not doing right by the malpractice insurance. The premiums are too high. Well, Mr. Chairman, that may very well be the case. But really I do not think this panel of intelligent Senators is going to be mislead into thinking that if we just adjusted the malpractice insurance premiums we would solve this problem. It is a very, very interesting diversion from the real problem but does not make any sense.

Now why should the Federal Government get involved? I will give you my version. In 1992 the Federal Government will spend $216 billion directly in health programs, about 30 percent of the health spending. Moreover, the Federal tax subsidy for employer-provided health insurance will finance another $185 billion in health care, a total annual budget cost of $65 billion.

So for anyone who wonders whether we should have an interest in solving the nation's malpractice problems I think that ought to be sufficient. I also want to suggest that there are some proposals around to solve this problem piece meal, one State at a time. I submit to you that if you do it that way and if that is the way you end up passing the law around here what you will do is delay for many, many years the efficacy of such changes.

Doctors and the delivery system will not change just because liability is changed in their immediate area. It will have to be changed nationally in order to affect a change in the health and delivery of defensive medicine. It is just obvious. There will be a gravitation to the standard that defensive medicine pushes them, even if it does not apply to them, unless and until we do something nationally.

So you might ask, even though you are conducting hearings on this issue separately, should we proceed with comprehensive medical malpractice reform before we pass new medical delivery system reforms? I only tell you that unless there is some political reason to tie the two together, and I do not really understand that, I mean I do not think that is the case, then I think you ought to proceed to address the most significant pervasive issue, and that is rising health care costs. And you ought to address it by reforming the medical malpractice system as soon as you can and the rest of the system can come along in terms of the reforms that you and others have in mind.

I would just close by saying I have an approach to how we should do it, but that is not the purpose of this hearing. I have obviously attached my approach to the record here today and the committee by referral has my bill before it.

But I suggest that if we are going to do it, we ought to reform it in a wholesale manner. I submit that we ought to take it out of the courts and away from the juries and put in binding arbitration across this land, with some caps on it and then adopt a system that forces the profession, the medical profession, to police itself better and give them more authority, either through our laws or challenge our States to do it so there will be policing rather than evasion by the doctors themselves as to their professional activities.

I would be pleased to answer any questions that you might have. Thank you very much for listening to me. I am willing to do what I can to be helpful, Mr. Chairman.

Thank you, Senator Durenberger.

Senator ROCKEFELLER. Thank you, Senator Domenici, very, very much. I have two questions, actually.

One is on page 4 of your testimony. I am having trouble with my math. In the second to bottom paragraph you say that in 1992 the government will spend $216 billion and then you say, moreover, Federal tax subsidies by employer-provided health insurance total $65 billion annual.

Now my understanding is that Medicare is about, let's say rough numbers, $120 billion; Medicaid is about $50 billion, probably a little bit over that. Then I am having trouble with your $65 billion. Of course, that is revenue foregone. Do you have sort of a breakdown, other than Medicare and Medicaid of the $216 billion? Is there something?

Senator DOMENICI. Yes. CBO gave us this. I assume that if your two numbers are correct, then you would have to add a couple of other things. VA hospitals, Indian health, public health service, and the like, and you will get up to the number of $216 billion without the loss revenues because we permitted the deduction.

Senator ROCKEFELLER. Which we do not add on because that is foregone in this calculation?

Senator DOMENICI. That is correct. That is on top of, in addition to.

Senator ROCKEFELLER. Right. Okay, I thank you for that.

Secondly, just an observation. You said two things. At one point you are saying we really ought to get right at cost containment and the best way to do that is to go after malpractice reform, tort reform; and then I thought you said in order to really go at this, tort reform is not the whole answer, we have to take a comprehensive approach.

I want to know a little bit more how you feel about that within this context. Quite and totally separately motivated from another competitiveness point of view, I have been pursuing product liability for a number of years. It is my observation that if one takes out some of the particularly emotional things—there are 66 lawyers in the Senate out of 100 and we have to deal with that fact. If we go about lawyer bashing in phraseology or in legislation I think we get in trouble fairly quickly. So things like caps on punitive damages and liability is something I convinced Senator Kasten to drop from the bill and a series of other things which he would have liked to have done but which seemed to me to present a more moderate bill if we did not do that.

We have been able to pass that bill out of the Commerce Committee 13 to 7. Within the context of the 66 lawyers, and within the context of this highly emotional subject, where if you are for tort reform then you are viewed as anti-patient. Could you respond to that?

Senator DOMENICI. Well let me make one observation about that. First of all, are you a lawyer, Mr. Chairman?

Senator ROCKEFELLER. I am not.

Senator DOMENICI. Senator Durenberger?

Senator DURENBERGER. Yes.

Senator DOMENICI. Senator Baucus?

Senator BAUCUS. Yes.

Senator DOMENICI. Well, I am, too. And I have three of my eight children that are lawyers. One will be shortly. He is at Stanford so it will be another 3 months or 4. But, frankly, I bash lawyers all the time and tell my own children that we surely do not want anymore. I am doing my very best to talk them out of it. I do not know if I can.

We are going to have so many lawyers. Let me tell you, we already have this occurring. The fastest growing tort in the courts is now lawyer suing lawyer for lawyer malpractice. Can you believe it? You know, we were filled up with suing doctors. Now we are suing each other. Maybe the end product will be less lawyers when we are through with all this. I do not know.

But in any event, I do not agree with your premise that in the Senate a bill which seems to address the inefficiency and enormous costs of litigation versus the benefit, I do not think that will be construed to be lawyer bashing. But you will have lawyers who are practicing law who are making the money who will think it is more than lawyer bashing. You can count on that.

For those who are in that position, they like it just like it is. So, frankly, I believe that we ought to take it one at a time. I, frankly, do not know of anyone who has looked at this profession and this delivery system that thinks the approach of torts in the courts as it has evolved in American juris prudence over the last 100 years is really very good.

Now maybe you will get some witnesses here today. But I would suggest that when you are finished talking about their selfish interest it will really come out that they like it because it is good for them. That is not our concern. This is too big a problem.

So I think you ought to go where you can and that is reform the malpractice system. As to the rest of the inflationary spiral in health care costs, let me tell you, I have tried as hard as any of you to get to some three or four things that I think we ought to do and it is just tough. This at least will bring some part of it under control. But I do not know how we are going to get the rest of it under control.

I have not yet made up my mind. I have tried some things and I am working on them like many of you, but I do not know how to get the spiraling costs out of health care costs.

Senator ROCKEFELLER. Thank you, Senator.

Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, let me just say to you that while in your capacity both as Chairman of the Subcommittee and as Chairman of the Pepper Commission and along with some of the rest of our colleagues in this committee we are trying to get out of a bipartisan, nonpartisan comprehensive universal access bill.

We Republicans were trying to see where we had common ground to stand with all of you. We found there are many areas where we stood on the same ground; and many areas where we thought maybe an incremental approach was preferable to a comprehensive approach.

But one of the things that some of us learned during the process of weekly meetings, we got together at breakfast every Thursday morning, is how strongly many of us who were lawyers in this system felt. Not that there is no place in America for lawyers.

Senator DOMENICI. Oh, no.

Senator DURENBERGER. Not that there is no place in this country for the kind of resolution system off of which many of us may be living for some period of time, but the more we knew and the more we learned about health care and medicine and medical practice in America, the more we were driven to say that the only way you can guarantee that the negligence that does occur in medical practice in hospitals and doctors' offices in America, the only way you are going to make sure that people are adequately compensated for the shortcomings in the system, is to get it out of the courts and get it into another process.

I do not know anybody who feels it more strongly than our colleague from New Mexico. Pete, while you were speaking I was glancing over the—because this is sort of a new field for me—testimony of the witness from Public Citizen. And the point that seems to be made by their Association is that any effort like you are trying to make or I was trying to make yesterday in my bill and others are trying to make is that, it limits victims' rights. But we do not limit victims' rights, whatever that is. We limit negligence.

Then they go on to make recommendations which I think you will find in most of our bills, which is better doctor discipline, better doctor education, insurance reform, improved physician training and oversight, that sort of thing that is included in most of the recommendations. But the notion that somehow or other the reformists are limiting victims' rights, I will ask Ms. Gilbert how she comes to that. But you have been at this longer than I.

But maybe in view of the facts about how many of these cases ever see the light of day, how many people ever get into the courts, if they get into the courts, who gets compensated and who does not, how in the world can you characterize your reform measure, for example, as limiting victims' rights?

Senator DOMENICI. Well, Senator, let me tell you. Really to fall for that is to assume that the current state of liability is inviolable, perfect, ordained by God. The current status of victims' rights is manmade. It is either common law, which means we borrowed it from Great Britain, or it is statutory. Let me just suggest, if we had no fault victims, no fault liability, and had it for 15 years and doctors were liable if the thing did not turn out right and no fault had been rocking along and we were saying, well the time has come to think of negligence instead of no fault, the victims' rights people would be coming up here saying, do not tinker with the victims' rights.

It just is not so. There are no inviolable victims' rights. In some countries there is no right to sue at all. In fact, in many countries with much the same common law court system and tort system, you cannot even sue the health care system. Now that is a pretty good limitation of victims' rights. There just has not been a group growing up that is espousing that. It is just the State and others who are running the program.

So it does not seem to me that it makes too much sense philosophically. From the standpoint of the practice, I think the Harvard study gives us a reason to say, why don't we get it into a more everyday, common approach to liability, via something like arbitration?

Let me tell you, there may not be so many lawyers complain about this once they find out that we are moving in that direction. I should have told the Chairman this. Frankly, if you go to arbitration history indicates that a lot of lawyers will go to those cases. They will not be these experts that have to be the greatest in the world and even have medical doctors on their staffs or have them on call for extremely high kind of professional consulting fees because they will take small cases to arbitration and everyday lawyers will be in there.

In fact, if you want to refute those who oppose it, call a meeting of your Bar on a broader base than your trial lawyers and tell them you are going to bring them some everyday business instead of the other guys the big time business.

Senator DURENBERGER. Thank you.

Senator ROCKEFELLER. Thank you, Senator Durenberger.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Senator, I think you are quite provocative here and have some interesting ideas. I think you are beginning to touch on part of the problem, namely ways to limit excessive litigation in this country. I am reminded of de Tocqueville's observation. Frankly, that is why I went to law school, I read de Tocqueville when I was in college. He observed that American lawyers have more of a working understanding of the nuts and bolts of the American society than any other profession.

So I thought when I was back going to school and college in the early 1960's, well, gee, I want to understand what is going on in America so I will go to law school; I will be a lawyer. But it is clear, frankly, that de Tocqueville observation is as accurate today as it was then. That is, lawyers, probably as much as anybody in any single profession, are more involved in all our society's various ramifications than any other profession.

One has to ask why was de Tocqueville accurate when he wrote about America a century and a half ago or whenever it was, and why there are so many lawyers today compared with other countries. Frankly, I think part of it is just the nature of our country.

Our founding fathers left Europe to escape tyranny, they distrusted power, they distrusted government. So they wrote a Constitution with divided powers, various branches of government, and adopted a Bill of Rights to provide for individual protections. We have a Constitution that has more individual protections than any other country's constitution, by far, as individual liberty protections. So if we add that all together we just like to be independent people. We like to do things as individuals our way. We like to run to the Constitution to have our individual rights protected.

All that is fine. All that is good in a certain sense. But I also believe this country has got to come together a little more. We have to quit fighting among each other and start working together a little bit more, certainly if we are going to be competitive in the

world with respect to the Japanese and the Germans and other countries.

So I think that you are on to something. It has to do with standing to sue. It has to do with the damages or not that may be awarded, and administrative remedy probably has a place in all of this. No fault seems to have worked in the automobile injury area in most cases and we have workmen's compensation to address injuries in the workplace. I think that has basically worked.

In my State of Montana it has gone a little too far in some cases, however. But it is clear that the piece of the puzzle we are addressing today is a necessary piece that must be addressed. I think the American people are slowly beginning to realize that this is a part of the puzzle that must be addressed as long as we do it responsibly and with utmost attention to individual rights of people who may suffer some injury, either by a physician or in a hospital and who do not have resources to sue and so forth. There must be some way to ensure that they are not only protected, but that some system is in place to keep hospitals and doctors on their toes so that they perform with utmost diligence.

I thank you for your contribution.

Senator DOMENICI. Thank you very much, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Baucus.

Senator Daschle?

Senator DASCHLE. Mr. Chairman, I have no questions.

Senator ROCKEFELLER. Senator Domenici, thank you very much for coming and spending the time on this important subject.

Senator DOMENICI. Mr. Chairman, you made a point just by way of a question of talking about the product liability, at least your approach to it.

There is another reason that I think we have to look at litigation, be it product liability or medical malpractice, where we might not have looked at it 20 or 30 years ago. I think you all know me well enough. I really think this is a magnificent country. I am even, to some extent, naively proud of the country. Maybe it is because both of my parents came from a foreign country.

But, you know, sometimes you have to face up to reality. We may not be affluent enough to be able to afford the tort system in medical malpractice and we may be reaching the point where we cannot afford the liability that is there on products in the country. You know, after all it is a cliche to say there is no free lunch. But when you finally look at the overall system, I mean to produce goods and wealth means you have to produce new goods and wealth over the last year for it to be growing.

And if you are just taking it out on the bottom end all over the place and these kinds of things that we are talking about here today and others, I do not know when or if ever, but clearly these are very big negative drags on economic prosperity, which I think is probably more important aside from our value system, than for anything else for the people of the country. Everything else pales if you do not have economic prosperity. And the value system is up to people, not up to us, essentially.

But I think those are the two. And all the rest have to be subservient in one way or another and maybe that is why you have to do some of these things.

Senator ROCKEFELLER. And some might argue that a value system in economic prosperity can be interrelated.

Senator DOMENICI. We will talk about that another time but I agree that they are and I think you do. Thank you very much.

Senator ROCKEFELLER. Thank you, Senator.

Our second panel consists of Dr. Troyen Brennan, who is associate professor of internal medicine at Harvard Medical School. Clark Havighurst, William Neal Reynolds professor of law at Duke University School of Law.

Gentlemen, I assume somebody is going to be putting proper name tags and place tags in front of you. But we are glad that you are here and, Dr. Brennan, perhaps we would lead with you, sir.

Senator DURENBERGER. Could I do a brief statement?

Senator ROCKEFELLER. Yes, excuse me. Senator Durenberger?

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, if I might and with apologies to the witnesses, we deferred opening statements to our colleague Pete Domenici and also because it is just a lot more fun listening to all of you than it is to the folks up here. But as I indicated earlier I am relatively new to the field, although, Clark, you and I have discussed this subject a few times over the last 12 or 13 years since I have been here.

But I think I have learned a lot about the role of medical malpractice and some of the product liability issues over the years, particularly as they relate to the quality of medicine. Yesterday when three of us introduced a slightly modified approach to medical liability reform I tried to express what we were doing in the larger context of my experiences with the medical care system and with the people of this country who clearly want three things out of the system.

They want access. They want quality. They want affordability. They want to be able to find a way to afford this system. It is clear that the system we have today is broken down; and the part we are addressing here today, the one that is supposed to guarantee quality, is probably as broken down as any part of the system. And the search that is on in this subcommittee today is to find out what role liability, the currently liability system or a new liability system, would play in helping to improve the quality of care in this country, while also improving access or at least not making it any worse, and dealing with the affordability issues as well.

I am just going to briefly summarize the three parts of the problem that I see the current liability system fosters. On the access side liability is expressed usually in terms of liability premiums. I think we all know the way insurance premiums are put together. They take a medical specialty and they treat everybody the same—the general practitioner, the family practitioner gets the lowest rate. But the good practitioner gets the same rate as the poorest practitioner. That is the way the system works. It is a lousy system. But that is the way it works and it raises the price of the good family practitioners all over America.

When you get up to the neurosurgeons or the cardiovascular surgeons they are eight times as high as the lowest person and the careful people, the highest quality person pays the same price as everybody else. But the net result is you cannot get obstetricians and gynecologists to go to rural West Virginia or rural Minnesota or places like that because of the cost of their premiums. So that is the access problem.

The cost problem is illustrated by the chart over here. The top chart shows you on the green line on the bottom of that chart is the CPI over the 1980's which has gone up about 30 percent. The red line is physician fees which have gone up about 50 percent, despite the component of physician fees is the blue line which is professional liability premiums and that has gone up 160 percent.

We can sit here and blame insurance companies for that all we want. The reality is that the current liability system designed to improve the quality of health care ends up in a 160 percent increase. For those who would say we had another one of those 1976, 1986 every 10 year problems from insurance companies in America you can acknowledge that within the last couple of years that big growth has leveled off. But you can also acknowledge the expectation that is probably going to rise again unless we do something about the problem.

The real gripper though is when you get to some of the five worst states there, the liability premium rates in 1988, and put it in the context of costs of access to particular professional expertise. Take a State like Florida which is obviously the most egregious example, the internist is $21,143 a year; a general surgeon will be paying $1900 a week; and in obstetrics it is $700 a day. So if you want to get a definition as to the cost aspects of this, that is it.

On the quality side, quality can be defined simply as patients getting what they need from their doctor and not getting what they do not need. I am not going to spend time this morning tell us about all the things we already know from any independent study anywhere in America about all of the unnecessary medicine that is being practiced in America today.

You can blame it on a variety of things, over our fetish for technology and a lot of things. But the so-called defensive medicine is clearly a part of that. My State is the second healthiest State in America next to Hawaii. My doctors and hospitals in my State in Medicare at least have the lowest charges of all 50 States.

And yet the complaints the doctors and hospitals in my State have, including the Mayo Clinic, which is supposed one of the better practices in America, is that their efforts at providing quality medicine are impeded by the efforts on the part of everybody outside the system to tell them how to practice medicine. And whether it is the trial bar or it is Medicare or it is 1,500 insurance companies or it is peer review or whether it is the $100 billion or the $15 billion or the $30 billion worth of outside advice to the medical profession, which is adding up all these so-called administrative costs, the problem in America seems to be clearly our aim is to penalize wrongdoing rather than rewarding excellence.

So the thrust, it seems to me at least, to reform needs to be to find a way to reward quality while making sure that anyone who suffers less than quality is compensated for that. That is a tough

thing to get through our current mind set. It is also tough, I think, to try and convince people that somehow or other the health care or the medical system is a little bit different from automobile accidents and things like that.

But to try to put it in the most appropriate quality context, physicians, hospitals, people in my State, want to be rewarded in some appropriate way for delivering quality care. They do not mind they and their colleagues paying a price, obviously, for less than quality. Because that is the way you can tell who is quality and who is not. But the current system does not appear to do that.

There seems to be only one group that supports the current system. I keep asking if anybody can argue with these figures, and maybe somebody will, but the source is the Rand Corporation Institute for Civil Justice. I hope this is not characterized as lawyer bashing, but these seem to be the people who support the current system, even though most people say that it is defective. That is where the current money goes in the system—56 percent goes to the patients; and 44 percent goes to the system of determining who is liable for what. We all know the rest of the data which is under the current system, 97 percent of the cases never get adjudicated. I think you know all the rest of these statistics.

So that is just by way of background, Mr. Chairman. I appreciate your listening to my efforts to put this in all three contexts—access, quality and price. And just to say to you, Mr. Chairman, the one thing—there are probably several differences in some of the liability reform proposals that are before us today—but the one effort that Jack Danforth and Conrad Burns and I tried to make in our proposal yesterday that might merit your taking another look at it in light of what you are able to accomplish in the Commerce Committee is that we have incorporated all aspects of liability into this, not only professional liability, but drugs, devices and product liability as well, which may double the opposition to it. I am not sure.

But it seems to put in context the totality of quality that Americans expect when they go to see a doctor. They do not want to see the drugs over here, the devices over there, and the doctor or midwife over here. They would like to see it in one experience because that is the way we look at it and that is the way we have postured our reform.

Senator ROCKEFELLER. Thank you, Senator Durenberger. I apologize for not calling on you more promptly.

Senator Baucus, Senator Daschle, do you have any—well, we have not really done opening statements.

Senator DASCHLE. We have a lot of good witnesses waiting, Mr. Chairman. I would suggest we proceed with those.

Senator ROCKEFELLER. All right. We will proceed to those good witnesses.

Dr. Brennan, again, we would start with you, sir.

STATEMENT OF TROYEN A. BRENNAN, M.P.H., M.D., J.D., ASSOCIATE PROFESSOR OF INTERNAL MEDICINE, HARVARD MEDICAL SCHOOL, BOSTON, MA

Mr. BRENNAN. Thank you very much. I am an Associate Professor of Internal Medicine at the Harvard Medical School and have been involved for the last 5 years in what is called the Harvard Medical Practice Study. I think what I would like to do today is just overview the results of that study.

It was designed to answer four critical questions. First, we wanted to know what the incidence of adverse events, defined as injuries caused by medical practice as opposed to a disease process was in American hospitals, specifically New York hospitals, as this study was paid for by the Department of Health of the State of New York.

We also wanted to know what the incidence of negligent adverse events was, those medical injuries caused by substandard care.

Second, we wanted to know the relationship of these adverse events and negligent adverse events to malpractice litigation occurring in New York.

Third, we wanted to know the costs of medical injuries sustained by patients and in particular wanted to understand whether or not a no fault system of medical injury compensation could be affordable.

Our fourth goal was to find out a preventive affect of litigation.

To answer these four questions we employed the following research plan: First, we reviewed 30,000 medical records randomly selected from 51 hospitals in New York in 1984. Cases were reviewed by as many three physicians who judged whether or not an adverse event had occurred and then decided whether or not there was evidence of the presence of negligence.

Second, we reviewed all 67,000 medical malpractice claims in New York from 1975 through 1989 and employed a matching process to undercover those cases of litigation which arose from the cases we had studied in our record survey.

Third, we conducted over 2,000 telephone interviews of patients, half of whom had suffered adverse events to evaluate the economic damages associated with those injuries.

Fourth, we took advantage of geographic differences in claims rates and in injury rates to complete an econometric analysis of the relationship between litigation and high quality medical care.

Briefly the results are this: First, the adverse event rate in New York hospitals was 3.7 percent and the negligent adverse event rate was 1 percent. This means that for every 1,000 admissions to a hospital in New York in 1984 there were 37 injuries due to medical management as opposed to the disease process and 10 such injuries that were caused by substandard care.

Of the 2.6 million discharges from New York hospitals in 1984 there were then 98,000 adverse events and 27,000 negligent adverse events. The majority of these led to short-term injuries lasting less than 1 month. However, there were negligent adverse events that led to 7,000 deaths and over 1,000 permanent and total disabilities.

An epidemiological analyses of this data that we have done subsequently we found that the only significant individual risk factors

for negligent injuries were age greater than 65 and the lack of health insurance.

The second major finding was that there were 3,600 malpractice claims in New York in 1984. We estimate that almost 3,000 of these arose in cases where there was no negligence or no injury. Conversely, less than 3 percent of negligent adverse events lead to claims. Thus, there is a stunning mismatch between malpractice claims and an objective measure of medical injury.

Third, we have estimated that the costs of all injuries attributable to adverse events for which there were no collateral sources of compensation was approximately $1.1 billion in 1989 dollars. This is quite similar to the amount New York doctors and hospitals paid in malpractice premiums in 1989, suggesting that a no-fault system is affordable.

And finally, our econometric model demonstrates that areas of high claims rates have lower injury rates. This suggests or indicates that there is some deterrent affect of litigation. We conclude from this that a no-fault system should be tested. Our research indicates that a no-fault system of compensation could provide more rational and efficient compensation of all injuries, not just negligent ones for costs similar to the tort litigation system.

As an organizational structure for this approach we would propose a strict enterprise liability model based in hospitals that would be underwritten by sharply experienced rated liability premiums. This approach would arguably provide more appropriate deterrent signals than does our present system. In any case, our research suggests that reform is a priority.

Thank you for your time and if you have any questions I would be happy to try and answer them.

Senator ROCKEFELLER. We will, Dr. Brennan. Thank you very much.

[The prepared statement of Mr. Brennan appears in the appendix.]

Senator ROCKEFELLER. Mr. Havighurst?

STATEMENT OF CLARK HAVIGHURST, J.D., WILLIAM NEAL REYNOLDS PROFESSOR OF LAW, DUKE UNIVERSITY SCHOOL OF LAW, DURHAM, NC

Mr. HAVIGHURST. Thank you, Mr. Chairman. I am Clark Havighurst. I teach law at Duke, specifically in the field of health care law and policy. Because a major purpose of this hearing is to clarify the Federal interest in the law of medical malpractice, I have tried in my statement to isolate the area of the greatest concern to the Federal Government by distinguishing it from what I call the conventional reform agenda.

The conventional agenda of malpractice reforms includes most of the things that the States have been urged to do for many years, with only limited success. They include limits on damages, limits on the form that damages can take, some procedural reforms, a few changes in the law of evidence, perhaps changes in the rule of joint and several liability, and efforts to encourage the use of alternative dispute resolution methods. These proposals mostly originated with

the medical profession or people sympathetic to it. They have been opposed by plaintiff's lawyers and some consumer groups.

When I look at the conventional reforms I see some merit in some of them. But I do not think the cost of liability insurance itself is an issue. It depends on what you get for that money, not whether the outlay is big or small. Liability insurance costs are really quite small in proportion to medical costs nationally—about $7 billion versus about $700 billion in total spending.

On the other hand, it is important that the risk of malpractice liability be kept insurable. There have been times when the risks have been so unpredictable or changing so fast that the availability of insurance has been in doubt or its cost has changed dramatically, imposing real hardship on providers. Those are problems that should be addressed.

There is also a problem about the high cost and arguable unreliability of the litigation system that we have for evaluating claims. There are some reforms there that could be usefully imposed.

But I have not been persuaded that the conventional reform agenda should be addressed at the Federal level. Although there are some legitimate concerns, as I have stated them they are not at the heart of national health policy. Traditionally, these are issues that are dealt with at the State level, and I do not yet see any reason why they should be addressed Federally. Of course, the Federal Government might decide to adopt a set of reforms for Federal programs like Medicare. And if we should go to some kind of single-payer system then, of course, the government would want to think through the liability issues associated with it. But I do not see yet enough of a general Federal stake in this issue to warrant preempting State tort law or the rules governing the administration of justice in State courts.

Now that is what I have to say about the conventional agenda. I do not feel very strongly about it but I have not been persuaded that the issues addressed by the proposed reforms are important enough for Federal action. I certainly appreciate the efforts that many in Congress have put into trying to think through what reforms might make sense and the impatience you have with the States in this area. It is not an easy matter and reasonable minds could differ.

One reason I have emphasized the lack of a Federal interest in pushing the conventional agenda is to emphasize how great Federal interest I see in another particular aspect of the law of medical malpractice. This is an aspect that the conventional reform agenda does not address, directly or even indirectly, in any substantial way.

What strikes me most forcibly about malpractice law is its attempt to enforce a particular centrally determined standard of care against all providers of health care in America. That is what the legal system does. The law regularly compels, or at least it is perceived to compel, the utilization of costly services, of diagnostic tests, of expensive procedures of all kinds, of high-cost rather than low-cost inputs. It essentially leans toward requiring the system to spend more. The law rarely asks any question other than whether there is a health benefit to be derived from extra spending. It never asks, is the benefit worth the cost? Sometimes it is rather

quick to conclude that is a benefit when in fact there may not be one.

In my statement I develop at some length the thought that malpractice law is imposing a form of command-and-control regulation on American health care, compelling physicians to adhere to prescribed standards of care—not always telling them exactly what to do in a given case but generally expecting them to intervene quickly and expensively whenever there seems to be an opportunity to do so with a remote possibility of benefit. Physicians perceive this as a kind of regulation. They see the law imposing rigorous sanctions on them whenever there is an injury that might conceivably have been prevented. Thus they strive to comply with what they think the law's requirements are, just as they would comply with regulatory requirements of an explicit kind.

Because doctors tend to think that the law is unreasonable they tend to act unreasonably in many cases. This gives us what we call defensive medicine, as physicians, giving the law a wide berth, incur costs that the law probably would not require them to incur in fact. That kind of defensive medicine is a problem.

But I see a serious problem in the law's actual standards as well. Those standards may be very wasteful, requiring physicians to spend society's resources unwisely. The legal standard of care that the courts enforce in malpractice cases has never been adopted as public policy in this country. Instead, it has been borrowed from the medical profession by courts who simply assume that the medical profession's requirements are socially beneficial. But the profession's requirements have not been evaluated to ensure that, at the margin, the benefits justify the cost.

The law's standards are drawn from customary medical practice. One thing we know about medical practice in this country is that it has developed under a financing system in which cost is literally no object. In enforcing medical custom, we are enforcing inefficiency.

Now if you want to explain why American health care costs are so high it seems to me that you do not have to look much further than this. Providers are bound by law to deliver only high-cost, state-of-the-art services. Americans thus have only two options in buying health coverage. Either they buy the first-class Cadillac-style care that the law requires providers to provide or they go uninsured. Too many have had to choose the latter option.

As is not the case with the conventional reform agenda, the Federal Government has a clear interest here. The overspending required by malpractice law drives up the cost of public programs directly. It also drives up the cost of privately financed care, which the Federal Government subsidizes through the tax system. Malpractice also contributes to the large number of uninsured persons. Lower-cost options in the market, which the law now precludes, would allow more people to insure themselves and make it cheaper and more feasible for the Federal Government to take care of the rest.

Now, Mr. Chairman, I was going to go on and talk a bit about practice guidelines as a solution to the problem I have identified. To summarize my thought, I think that practice guidelines could make the legal system a somewhat better regulatory program than

it is today. I do not deny that at all although I think it may not do all we might hope it would do to lower the costs of administering malpractice law and to clarify its requirements.

My real interest, however, is in thinking more broadly about practice guidelines and how they could also serve, not to make malpractice law a better regulatory system, but to help us deregulate medical care by giving consumers new means of making and implementing choices about the health care they wish to purchase. If there were a variety of guidelines among which people could pick and choose in designing organized health plans, consumers would have for the first time an effective means of means of selecting what best suits their tastes and their pocketbooks.

It seems to me that practice guidelines could give consumers something they have never had before, namely the means of specifying exactly what they want to buy from the health care industry and of expressing those expectations in contracts. Such contracts would then become the rules that are enforced in lawsuits that might arise down the road. I have been pushing this idea as far as I can because it seems to me to offer practical solutions to the otherwise insoluble dilemma of how to limit spending on health care in the United States.

Senator Domenici's bill, S. 1232, incorporates some of my thoughts about how practice guidelines might be adopted as contractual standards which would then govern in liability suits. I think Senator Domenici's bill is the most interesting of the bills I have seen. I have not seen Senator Durenberger's yet. It is a Federal reform that does make sense. Unlike the conventional reform agenda, it goes right to the heart of national health policy. Its key feature is that it would allow people to select and specify standards of medical care that are more precise, clearer, and possibly cheaper and more affordable than those that the medical profession has given us.

Thank you.

Senator ROCKEFELLER. Thank you, Mr. Havighurst.

[The prepared statement of Mr. Havighurst appears in the appendix.]

Senator ROCKEFELLER. Dr. Brennan, let me start with you. I think that your study was mostly within the State of New York.

Dr. BRENNAN. It was based entirely within the State of New York.

Senator ROCKEFELLER. Was it not the largest study ever undertaken on this subject?

Dr. BRENNAN. I believe it is the largest study.

Senator ROCKEFELLER. One of the things that is contentious in this debate is if one has liability it deters adverse behavior. I would be interested in your views about whether or not the fear of liability serves as a deterrent, in your judgment. I think you said that doctors perceive the likelihood of a suit against them to be three times more likely than in fact it is. But in any event it is very much on their minds.

Could you discuss how you feel about the deterrence factor in our present system?

Dr. BRENNAN. Well if you look at the system from an objective point of view, sort of matching up the medical injuries to the suits,

a situation like this is like there is a traffic cop who is out there giving a lot of tickets to people who are not speeding, but a lot of people who are speeding are not getting tickets.

So it is hard to understand how that could possibly produce much deterrence. However, we do find that somewhere less than 3 percent of negligent adverse events lead to suits. And yet most doctors think that, when we polled doctors about this, people believe that their chances of being sued if they are involved in a negligent adverse event are about 60 percent. So although there is a weak deterrent signal out there, doctors seem to be picking it up.

Hence, in the proposals we put forward about no-fault we do not think you can go to a no-fault system like New Zealand or Sweden that does not have some built in deterrent effect. We think the best way to go about deterrence is to rationally bring it inside the hospital and have the hospital economically at risk for any injuries that occur.

Hence, it causes the administration of the hospital and the medical staff to take seriously their high injury rates. We know these injury rates vary a great deal from hospital to hospital. So we think hospitals, if forced to, can find ways to decrease these injury rates.

So I think there needs to be some deterrent put into place if you replace the tort liability system. Although our econometric data on that is fragile. It shows that there is some deterrent affect depending on how you model it.

Senator ROCKEFELLER. Well I understand your words, but I think there has to be a greater conclusion somewhere after all of that work. In other words, if we replace the system you say we would have to have deterrents in it. On the other hand, you do say that doctors perceive there is a three times greater likelihood that they are going to be sued than in fact there is.

What do doctors say to you about that? Does it make them practice differently? Does it make them do more? Does it make them more nervous? What effect, to the extent that you can measure it, is there with deterrents?

Dr. Brennan. The best information we have on that is a series of about 150 structured interviews we did with doctors. If you talk to many doctors they will say it is ridiculous to think that the fear of suit is what makes me careful. I am careful because I am committed to my patients. I think that myself and all my colleagues feel like the fact that you may be sued has nothing to do with your commitment to high quality care.

Senator ROCKEFELLER. So they take notice and are concerned about it but it does not effect their behavior?

Dr. BRENNAN. They are concerned and nervous about it, but they say it does not affect their level of carefulness to individual patients.

Senator ROCKEFELLER. Do you accept that?

Dr. BRENNAN. That is the way I feel. That is the way most of my colleagues feel. On the other hand I realize that people are affected by overarching systems and I think that the fear of being sued at times does affect us. If you know that you may be sanctioned, you are going to be more careful. Although from a professional point of

view I think that is a difficult thing for myself and for most physicians to admit.

Senator ROCKEFELLER. But then I do not understand your conclusion. Because you basically said that they are aware that they might be sued, but that it does not really have an effect on their behavior. I think you just said that. Then you have also just said that it just might. I do not know where you are on it.

Dr. BRENNAN. Well, I am of two minds about it. I guess my comments are reflecting that.

But I think the bottom line is that there is some deterrent affect. It is difficult to measure and also difficult for doctors to define associated with malpractice litigation and that we should have any system that compensates people should also have some built in deterrent affect in it.

So I guess my bottom line is that malpractice litigation likely does make people at least somewhat safer and there are ways of designing liability systems that would, in fact, make them even more safe.

Senator ROCKEFELLER. A final question for the moment. The word "defensive medicine" is one of the few words that is understood about health care public policy. In that you have said that deterrents may be intellectual but not behavioral, is there then no effect on physicians with respect to defensive medicine? Just answer that if you can, please.

Dr. BRENNAN. A complicated question. Defensive medicine is nearly impossible to measure. Because there is no good way to find out exactly where one leads off being a good, careful physician and one becomes a physician who is just practicing defensive medicine. So I do not think we are ever going to get a great study of defensive medicine and find out exactly how large it is.

I think that many of the estimates that people put forth have politically purposes associated with them. Thinking about a tort system from a sort of theoretical point of view you could imagine a system that had very little deterrent affect, but had a great deal of over deterrence, especially if it was fairly easy for people to engage in over deterrent behavior.

In a medical setting it is fairly easy to be over deterrent. You can order more tests. They are cost-free to you as a physician ordering them. You are not looking at how much it is going to cost the patient or their insurance company or the government. So there is reason to believe that there would be defensive medicine—that there could be a good deal of defensive medicine associated with malpractice litigation and yet only a minor good side of it deterrent affect. So there could be lots of over deterrence and little deterrence.

Senator ROCKEFELLER. With my colleagues' forbearance, let me pursue that one step further.

Senator DURENBERGER. Please.

Senator ROCKEFELLER. Rand says that 30 percent of all medical procedures may be either inappropriate or unnecessary.

In your judgment, to the extent that defensive medicine causes more procedures, some of which may be unnecessary or inappropriate, of that 30 percent, roughly, what role do you think defensive

medicine plays in the number of tests or procedures that are inappropriate or unnecessary?

Dr. BRENNAN. From the data we have in New York we can explain very little of the variation in practice that you see as a result of changes in levels of litigation. So my estimate would be of that 30 percent probably something like 4 to 5 percent of it would be explicable through defensive medicine.

Senator ROCKEFELLER. Thank you, Dr. Brennan. We will come back.

Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, thank you very much. Somebody is going to ask what this hankie is. It is a Twins homer hankie. The Chairman when he sat down handed me a little note that said I am a fifteen year old die hard Braves fan.

Senator ROCKEFELLER. For the sake of public safety I will not comment on the note that I received from my colleague from Minnesota. [Laughter.]

Senator DURENBERGER. There is always a disparity, I guess, in the way we approach issues in terms of looking at things in the way we know them versus the way we would like to look at them. I would like to follow up on the Chairman's very excellent series of questions. And maybe just by way of restating how I got involved in this.

My presumption is that nobody can define quality in medicine today. It is something we leave to the doctors as you pointed out in your statement, Clark. One of the things is that if we are going to get our hands around costs in this country we are going to have to do something about defining what quality is. So one objective in the reform movement is to try to reward quality. Part of that is defining it.

The second part of it that gets to be critical for me which is implied in the Chairman's question is, you want to be able to ensure that less than quality is compensated for in some way. You could do that just by saying that only the quality people will get all the business and everybody else will not, or you can make sure that people who suffer at the hands of a system that has to at least achieve some level—you might have super levels, but at least some level—anybody who falls below that standard as a patient has to be compensated by this system.

I would say that as a sort of newcomer to the reform movement in liability that is where I am. I mean I would like to be able to define what quality is and reward it. But I also want to make doggone sure that every single person whose doctor or nurse or midwife or the process, which is a preferable way of looking at it, falls below that standard, that person is compensated. And they do not have to go through 39 months and 44 percent administrative costs and so forth to do that.

Now what is intriguing to me about what I hear from both of you is the reality that the medical care delivery system forces us to use the latest available technology. In other words, it is a technology driven system. I heard Clark say this specifically. Our legal standards are drawn from medical practice. They have never been incorporated in the public policy.

It is just out there and the whole system drives us always to find a new, a better, or whatever it is, whichever is practiced somewhere, that becomes sort of the legal standard. If on the one hand we are concerned about costs going up with every new invention and on the other hand, you know, we are going to try to do something about costs, I do not know how those of us in the public policy business can stay out of the business of either controlling that growth and technology or controlling the rewards for that growth and technology or dealing here with definitions, more appropriate ways to define quality and to reward or penalize, I should say, the absence of quality.

So that is how as a national policy maker I am driven into the field of so-called liability reform. Now whether it is state-by-state or community-by-community or however we do it, it seems to me I am driven. If I want universal access, if I want to guarantee all the poor people in South Dakota and Minnesota and the rural areas access to health care I have to deal with the cost problem. And a part of dealing with that cost problem is dealing with our National value system which today rewards consumption of new and better and so forth.

Clark, would you respond to that.

Mr. HAVIGHURST. I heard Mark Pauly of the University of Pennsylvania say the other day that he visualized an HMO that would offer "last year's technology at last year's prices." That is an interesting idea. And it makes sense because a lot of people would be better off if they could save the difference from buying this year's technology—just as they drive old cars.

But the problem with Pauly's HMO is that it may be illegal, at least in a malpractice suit, for providers not to have and employ the latest technology. Of course, Pauly's approach is not the most practical way to define a low-cost set of benefits because some of this year's technology is worth its cost and some of the older technology probably was not. So the problem is how can we be selective in buying medical care. I do think that, with luck, the practice guidelines movement could ultimately give us the ability to select from all of the offerings out there the things that have been shown to have some real benefit and to exclude some of the things that do not.

I hope that guidelines will become not a new layer of regulation, but a new opportunity for consumers to exercise choice. Guidelines could allow a single health plan to tell patients just what it was willing to pay for and what the doctors in the plan were committed to provide—namely, care meeting that particular set of standards and rules. I find that exciting potential. We have never had the ability to write contracts of that kind in the past.

This approach would allow us to put a price tag on the consumer's different options. Peoples' values might then begin to change. They might begin to see that having the latest and best is perhaps too costly to afford. With guidelines, we could be assured that the economizing being done was reasonable, that people were making the cuts at the right places, that they were getting the benefit of what science and good expert advice reveal. Guidelines would allow health plans to selective cuts instead of clumsily lopping off some benefit that would cause major hardship down the road.

So that is sort of the vision that I have been working with. It may sound a bit Utopian. But the Domenici bill and the Federal practice guidelines program might lead us in that direction in time. We are probably a decade from having the kind of guidelines I would like to see. But we ought to be working at it. We ought to get the whole NIH harnessed to making guidelines, applying knowledge in practical ways, instead of concentrating only on pure science.

Senator DURENBERGER. Dr. Brennan, do you have a reaction to that?

Dr. BRENNAN. The practice guidelines is an interesting issue. I have had the opportunity recently in the past week, in fact, to offer the notion of practice guidelines and different levels of care for people with different insurance policies to a health law class at Harvard and to a torts class at Boston University and a class in health policy at the Harvard Medical school.

All these training lawyers and doctors were taken aback and actually quite aghast at the idea. They thought that it was simply unworkable and unethical. I think that Clark may think that is an appropriate reaction and take heart at that. Because it is an idea which challenges both doctors and lawyers.

But when I do think hard about it and I think that, for instance, most of my patients are people without insurance or people who are on Medicaid and if they have a practice guideline that does not allow them to get an MRI scan and I want to get that MRI scan, then what I am going to do is go to my friend Doug Adams who runs the MRI scanners at our hospital and say, Doug, won't you do this one for free for me.

So the question, you know, you will be facing doctors with this kind of set of new ethical decisions about who should get care and who does not get care based on what sort of practice guideline we have decided to purchase for them.

So I think it is something that is very challenging and requires a good deal of thought. I think that Clark tends to agree with that and says let's experiment with it and see where the problems are.

Senator DURENBERGER. Thank you.

Senator ROCKEFELLER. Can I just, Senator Daschle, if you will excuse me, pursue that.

You used the word "unethical" about practice guidelines. You were saying what some of the doctors or others at Harvard and Boston University might have felt. Part of the whole purpose of outcomes research, which is meant to be terribly, terribly important in terms not of standardizing medical care, but if you have five times as many angioplasties in Lynn, MA as in Grodden, CT, and they are approximately similar places, there has got to be a reason and maybe part of that could be solved by practice guidelines.

How do they become unethical?

Dr. BRENNAN. Well, eventually you are going to get to a situation where I am taking care of a patient who does not have health insurance and a poor person who cannot afford to buy these things out of pocket or say I am taking of let's make it a person on Medicaid and say that the Senate opts to have a lower set of practice

guidelines for people who are on Medicaid, eventually you are going to get to a situation where I have a patient who needs a test.

Senator ROCKEFELLER. We would not do that. I mean why do you assume that there would be a different set of practice guidelines for Medicaid?

Dr. BRENNAN. Well eventually what the practice guideline idea boils down to is, say the Senate does not do it and move it away from Medicaid, but eventually what it boils down to is if you opt for lower, the sort of bronze level, as opposed to the gold standard practice guideline, you pay a lower premium.

Senator ROCKEFELLER. But, Dr. Brennan, is there ever anybody who says that practice guidelines are going to be anything other than a single standard? I have never heard anybody talk of that.

Mr. HAVIGHURST. That is what I have been proposing, Senator.

Dr. BRENNAN. I think that is what Professor Havighurst is proposing.

Mr. HAVIGHURST. That approach has a lot of potential for allowing people to get care who do not get it today.

Senator ROCKEFELLER. Let me defer to my next round and go to Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman.

I am one of the newest kids on the block and I am trying to weigh a lot of what has been presented so far this morning. I am curious about a couple of things and I would like to lay out some thoughts and have you respond to them.

The first thought is that we seem to have come to the conclusion that the system is broken. I have not, but apparently most experts in the field have. If one looks at the amount of insurance premiums paid by doctors last year, $5.1 billion, 4.9 percent of total health care costs last year, that in my mind is not conclusive evidence that the system is broken. But I would be interested on your thoughts on that issue.

The second is that, if it is broken, why are we only going after the victims, rather than the providers? That is really what it seems to me we are saying by limiting victims rights, by keeping them out of the system. It is curious to me that we would go after victims rather than go after the providers.

Third, I really wonder how much of medical practice is defensive medicine, and how much is the good old fashioned American profit motive. That did not come up at all in any of these discussions, but I am curious. If we have a fee-for-service system, how are you going to define the difference between the profit motive and "defensive medicine" or providing the very best care for a patient?

That is something I am surprised has not come up yet in our discussions with two very profound experts here. We have a fee for service system and doctors who own their own equipment. If I owned my own equipment and I was losing money on it, it would not take me long to figure out I have to start prescribing more work on that piece of equipment. But that could be viewed as defensive medicine. Who is going to say? So I think we have to be very careful about defining defensive medicine.

Then the last observation. Again, I am just getting started here, so there may be all kinds of holes you can poke in this. But it seems to me that from what little I know about this issue, that

there are doctors that time and again are the ones causing the problem. I understand there are certain studies that have shown that a very small percentage of doctors are responsible for a very large percentage of all malpractice.

It makes me wonder before we get into a complete reform of the system whether it would not make more sense to go after those who are the perpetrators with greater disciplinary action, with greater efforts at weeding out the culprits. So you put all that into the pot and start stirring it up and it just seems to me that at least so far I come to different conclusions than you two have with regard to what the solution is. I would be interested in your response.

Mr. HAVIGHURST. Let me respond on your first question, about the victims. I am not sure about this chart up here, but Professor Weler in his book says that, while we pay into the liability system about $7 billion a year, only $3 billion of that ever reaches patients as compensation. That is a fairly small fraction, some victims are over compensated. Many are undercompensated or not compensated at all, as we know from the Harvard studies. The victims are not well served by this system. The bulk of the money ends up with the lawyers.

Senator DASCHLE. But who pays? Excuse me just a minute. Are you saying that the premiums are paid by the doctors?

Mr. HAVIGHURST. Yes, initially paid by the doctors. But premiums are built into fees, so the patients are going to pay it in the end. It all comes back to the consumer. So consumers are putting in that $7 billion and only getting $3 billion back. It is a bad insurance buy, Senator. It would not be something anyone would purchase if he had a choice.

Senator DASCHLE. Wouldn't that be an argument for insurance reform?

Mr. HAVIGHURST. The problem is the very high cost of enforcing the legal standard of care. We have to spend all that money in evaluating each claim to find out if there is liability or not. It is a very costly business, putting costly experts to work second-guessing what the doctor did.

So that $4 billion that goes into administration goes to lawyers and to experts. That is an inefficient system. Now the no-fault approach would cover many more people. It would not compensate as lavishly but would serve victims I think quite well. Whether it would cost more or less than the present system is another question. But it would surely be more attractive from a social insurance point of view. In addition, the scheme could be designed to deal with the problem of incompetent physicians by experience-rating the premiums for that insurance, so that providers end up paying more if their patients have poorer outcomes. And so you have incentives for them to avoid those bad outcomes that would be compensable under this system.

I wrote an article in 1972 proposing no-fault insurance in this industry, and one of these days we are going to adopt that approach. It is a very exciting possibility. I think from the victim point of view it is very attractive.

Senator DASCHLE. Well I know I am out of time. But I really hope that we can address what I consider to be a need to go after

those who may be causing the large share of the problem. Disciplinary action, it seems to me, is overlooked in this whole debate thus far, as well as the profit motive.

Let's try to figure out a way to take this extraordinary incentive to provide more services, and differentiate between the profit motive which is a very legitimate interest on the part of any provider and so-called defensive medicine.

Thank you, Mr. Chairman; and thank you, both witnesses.

Senator ROCKEFELLER. Thank you, Senator Daschle.

If I can just pursue this a little bit more. Out of your study, Dr. Brennan, you conclude that 3.7 percent of hospitalizations had adverse outcomes; 1 percent of all hospitalizations had adverse outcomes due to negligence; 57 percent of all adverse outcomes resulted in minimal and transient disability, using your words; but 14 percent of patients from negligence died; and 9 percent had a disability which lasted longer than 6 months. Then you say 8 times as many people suffered injury from negligence as filed a malpractice claim and 16 times as many people suffered injury from negligence as were compensated.

Now that is an extraordinary string of facts which indicate a lot of serious adverse outcomes, a lot of which comes from, at least substantial amounts, real negligence. Can I ask a question about doctor discipline and peer review organizations?

There is not much money available generally within States for this sort of effort. Describe what happens within hospitals. One of the things that interests me, when discipline is being made or when certification is being done or whatever analysis is being done, the relationship between somebody in a specialty making judgments about a physician in question from the same specialty, is there ever the question of more protection or more sympathy or whatever? Could you discuss generally discipline within the medical profession?

Dr. BRENNAN. I am not optimistic about any system that is going to rely on State regulation of doctors to bring about better quality care. First of all the States, many States, have budget difficulties right now and that filters down, so that their licensing group or their Board of Registration in medicine like we have in Massachusetts becomes underfunded and unable to deal with these problems.

Moreover, our research does not suggest that the lion's share of these problems can be laid at the feet of a few bad apples, where if we could simply get them out of practice we would have great quality medical care. What happens is, the good doctors like good any other type of person, occasionally makes mistakes. And in making those mistakes sometimes patients are injured.

Medicine is a very difficult technologically sophisticated field. Patients are very sick when they come in the hospital. They are fragile and they can be injured. I think the best way to go about bringing about better quality care is to put it at the feet of the hospitals until the hospitals try to understand the system of care here, try to come up with ways that decrease these injury rates, try to use notions of quality that industry has been using for the last 30 years to develop a safer place.

I think the best way to do that is to rely on insurance premiums that the hospitals have to pay. If my hospital saw its insurance pre-

miums shoot up 40 percent because we had a higher injury rate over the course of a couple of years then it would be in the interest of the President of my hospital to go the chairman of the Department of Medicine and say, put somebody smart in charge of this and have them figure out how to bring down these injury rates.

We know that injury rates vary more from hospital to hospital by an order of magnitude varying more from hospital to hospital than do inappropriate procedures. We see rates of adverse rates from between 5 percent to 5.7 percent. So a ten-fold variation in injury rates.

We know some hospitals are doing better than others. We need to figure out why those hospitals are better and have the hospitals that are not doing as well emulate them.

Senator ROCKEFELLER. All of this is within a context of gigantically spiralling health care costs which is burying the Federal Government, the State Government, the average American family, big business, small business. I mean in other words, we do not have much time for all this.

My final question. You talk about hospital-based administrative compensation schemes. What you are trying to do in all that, as I take it, is trying to find ways of preventing—Senator Durenberger talked about this—ways of preventing injuries before they happen.

Dr. BRENNAN. Right.

Senator ROCKEFELLER. And thus lowering incidents.

Let me split off to you, Mr. Havighurst. Within product liability you could make the case—I wanted you both, but I was trying to sneak in two questions in the form of one. In product liability one can make a case for Federal solutions because products travel interstate. You can argue that in medicine it is intrastate virtually always and some referrals are the exception, I suppose. Therefore, it argues more for a State response.

On the other hand, 50 States, you have indicated, Dr. Brennan, there is not much money for doctor discipline and PRO's, et. cetera. How do you stay—you said you did not feel strongly about it—but how do you stay with the State in the face of enormous national pressure to address the cost of health care?

And for you, Doctor, the question which I directed at you. Please.

Mr. HAVIGHURST. On the question of State versus Federal responsibility, Senator Durenberger and I wrote a bill some years ago to encourage Federal experimentation with no-fault concepts and some other tort reforms at the Federal level with the idea of demonstrating what could be done by private contract. We were going to use the Federal Employees' Health Benefits Plan as a vehicle for trying out some voluntary options. It was an interesting idea.

I do not oppose doing things like that at the Federal level. The no-fault idea is good enough that it ought to be studied very actively at the Federal level to see what we can learn. I think it has great potential for taking the money that goes into this system, using it to compensate people, but at the same time preserving incentives, even strengthening incentives, for providers to avoid those bad outcomes. We would not put each case through an evaluation process to see if the injury was avoidable or not. We would just pay on the basis of the injury and that would seem to me to have very exciting potential. So I would hope the Federal Govern-

ment would take an interest in it—experimentation first and, if you want to do a national program later, that would be reasonable.

Senator ROCKEFELLER. Prevention, Dr. Brennan?

Dr. BRENNAN. Well I think we have spiralling health care costs in this country as you put it. But we have not seen a lot of investment in quality of care. We have not seen a lot of investment in safety. I think that if we were to invest in safety then we would be saving ourselves a lot of money. Because these injuries when they occur they, of course, cause problems with household production and they cause wage loss, but nothing that they cause is a huge cost in medical care.

So that of that money that is flowing into patient awards more than half of it is going for health care costs associated with these injuries. So if we prevented these injuries at the outset, chances are we would bringing down our total health care cost bill by a reasonable amount. And quality and assessment of appropriateness I think go hand in hand. So I think if you could get hospitals off the mark and interested in these areas you would be able to address both your problems.

Senator ROCKEFELLER. Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, I want to make one comment in light of the question or the tenor of the question from my colleague from South Dakota. I see it is repeated in some testimony we are going to hear later on. That is the implication that part of the problem here is due to the profit motive and positions and so forth.

And while I do not argue with that thesis and I abhore what is going on in Florida and some other places, and I think we have a variety of studies out now to try to demonstrate the extent of it, I must also point out that the profit motive has a similar value in getting efficiency into the system.

The Mayo Clinic owns diagnostic equipment. It owns labs. It owns hospitals and so forth and yet the proof is in the pudding in terms of not only efficiency but quality of care and so forth in the Mayo Clinic. The Kaiser Health Plan, they own all of it. Profit is not the thing that is the dirty word in here. Profit is a motivating factor. The problems in this system are the way the fee-for-service system works and this multiplicity of third party payers and all of the outside experts trying to tell people who to practice quality medicine.

So if the self referral system is going to be used to debunk reform in this system I think they are choosing certainly an inappropriate and the wrong target to go after.

Thank you very much, Mr. Chairman.

Senator ROCKEFELLER. Thank you both very much.

Dr. Brennan, I have to ask this. I was at Yale University Medical School fairly recently talking with physicians, physician assistants, nurses, public health people, nurse practitioners. They said that preventive medicine is not taught at Yale Medical School. Comment, please.

Dr. BRENNAN. I would say that is an exaggeration.

Senator ROCKEFELLER. I am not talking about Yale, I am talking about medical schools in general.

Dr. BRENNAN. I would say that there needs to be more of a focus on preventive medicine and there is at least some education about preventive medicine. There is almost no education whatsoever about what it means to provide high quality medical care. So I think their point is well taken.

Senator ROCKEFELLER. But when you say preventive medicine what does that mean to you?

Dr. BRENNAN. Well preventive medicine can be a lot of things. Preventive medicine, the traditional preventive medicine fields would be something like occupational medicine where you go into the work place and try to prevent injuries there or you think about preventive medicine in terms of high quality prenatal care. Quality assurance, preventing medical injuries insofar as preventing medical injuries is another form of preventive medicine.

Senator ROCKEFELLER. All right. Thank you. I really do thank you and I also very much apologize to the witnesses who follow you because we have taken our time at this, but it is important. I am very grateful to both of you.

Our third panel is Karen Fennell, who is a registered nurse and represents government affairs, Department of the American College of Nurse Midwives; Pam Gilbert, who is legislative director of Public Citizens' Congress Watch; Danine Rydland, who is a doctor from my State of West Virginia, I might say, American College of Obstetrics and Gynecology; and Richard Smith, who is director of public policy, the Washington Business Group on Health.

Karen Fennell, maybe we can start with you.

STATEMENT OF KAREN S. FENNELL, R.N., M.S., GOVERNMENT AFFAIRS SPECIALIST, AMERICAN COLLEGE OF NURSE-MIDWIVES, WASHINGTON, DC, ACCOMPANIED BY SUSAN M. JENKINS, ESQUIRE

Ms. FENNELL. Thank you, Mr. Chairman. I am Karen Fennell, government affairs specialist for the American College of Nurse-Midwives. This is not the first time we have come before the Senate Finance Committee and other committees of Congress with our malpractice problems.

Throughout 1986 when nurse-midwives had no malpractice insurance, we came before you frequently to address this problem. Currently, today there are approximately 4,000 certified nurse-midwives in America. Certified nurse-midwives work interdependently with physicians, mainly obstetricians, with whom they consult and to whom we refer patients who develop complications requiring physicians' care.

We have not as a profession moved out of the malpractice crisis arena. We thought that with the passage of the Risk Retention Act of 1986, that moving to State control in this area, would relieve us of many of the problems that we had. But I am here today to report to you that the Risk Retention Act, in moving malpractice to a State level of control, has actually created more problems for us.

Today nurse-midwives are insured by a variety of insurance companies. Mainly, because of the malpractice crisis, nurse-midwives have moved to work for hospitals. In fact, 76 percent of our mem-

bership work in hospitals and another smaller percent work with physicians. Premium costs range in those practice settings from $4,000 to $25,000 per year, per nurse-midwife.

The other portion of our membership has sought the assistance of the College to create a nationwide insurance program. These CNM's work in community health centers, rural areas of the country and many of these own their own professional businesses.

In 1986 CNA insurance companies and a consortium of underwriters, reinsurers came to our assistance. We are in the fifth year of that claims made policy. Our premiums have matured to a level of $6,100 a year. While this might not seem much in comparing this premium rate to physicians, certified nurse midwives incomes fall far below the levels of that of physicians. The average nurse midwife in this country makes $37,000.

Mr. Chairman, I was in your State just 2 weeks ago and our nurse-midwives at their chapter meeting were talking about their problems of malpractice. The community health centers are telling us that they are not going to be able to afford increases in malpractice insurance. Our CNM's in that State make an average salary of $21,000.

CNA this year came to the college and informed us that they could not continue the business of insuring CNM's because it was not profitable. While the number of claims had not increased significantly over the past 5-year period, the severity of past reported payments has escalated ten fold. It is not unusual for a settlement of $1 million to be paid in patient awards.

We have been rejected by many blue chip companies—AIG, Interstate, St. Paul, Transamerica and Reliance—again stating "that profitability is difficult to support because of the political and emotional nature of this class." In response to this, CNA has responded to us saying that they would provide a safety net until we complete our search. This safety net would result in a 46.8 percent in premiums and also exclude all nurse-midwives who do home births.

While home births is a very small portion of the population, less than 5,000 births per year, it is the population that are in rural America, those where women do not have access to birthing centers and community hospitals.

I shall not spend time on Federal reimbursement policies. We have addressed some of our concerns in our testimony and hope that you will review them. Community Health Centers are of great concern to us. It is an area where nurse-midwives do seek employment. We have had much dialogue with the community health centers and would like to recommend to you today that we look at the Federal Tort Claims Act in regards to CNM's who are employed by community health centers.

There is only one other area I would like to draw to your attention, and that is the issue of surcharge. Some of you might have seen the surcharge case that is before the District of Columbia right now. There are 10 States in which surcharges exist—that is obstetricians and family practice doctors who either employ or collaborate with nurse-midwives have an additional fee, an additional charge placed on their premiums. These charges range from $300, to close to $14,000 a year.

Currently there are 10 States. I would like to enter for the record those States—Alaska, California, District of Columbia, Florida, Georgia, Michigan, Mississippi, Minnesota, Montana and Texas. While we do not have time to go into depth on the surcharge case, we have provided in our testimony the details of the case before the District of Columbia. Also with me today is Susan Jenkins, legal counsel to that case.

The College comes before you because of our concerns in insuring our members. But more importantly of that, if we cannot insure our members they cannot practice; and if they cannot practice they cannot serve the pregnant women of this country.

Senator ROCKEFELLER. Thank you very much.

[The prepared statement of Ms. Fennell appears in the appendix.]

Senator ROCKEFELLER. Ms. Gilbert, can we go to you next, please?

Ms. GILBERT. Sure.

STATEMENT OF PAMELA GILBERT, LEGISLATIVE DIRECTOR, PUBLIC CITIZEN'S CONGRESS WATCH, WASHINGTON, DC

Ms. GILBERT. Thank you, Mr. Chairman, Senator Durenberger. I am Pamela Gilbert, legislative director of Public Citizen's Congress Watch. Public Citizen has long been active in efforts to reform the health care system and to improve the quality of medical care. I very much appreciate the opportunity to be here today to present our very strong view that restricting the rights of victims of medical malpractice will not significantly reduce the costs of health care and will in fact be detrimental to efforts to improve the quality of health care.

Hundreds of thousands of consumers are victimized each year by negligent medical care. Public Citizen estimates that number to be anywhere from 150,000 to 300,000 consumers each year. Yet most attempts to address the problem of medical malpractice come in attacks on victims and their right to recover damages and not on solving the problem at its source, which is ensuring quality care and eliminating or significantly reducing medical negligence.

Now we are hearing from President Bush and Vice President Quayle and the American Medical Association that the crisis, the very real crisis in health care in this country is the reason we need to restrict the legal rights of victims. The claim is that limiting victims' rights will be the solution to the skyrocketing costs of health care. Nothing could be further from the truth.

Medical malpractice costs make up a very, very small part of overall health care costs. If we completely eliminated the right of injured victims to go to court to recover their losses we would make barely a dent in the costs of the health care system. In fact, those costs could be increased.

The greatest impact of restricting access to the courts would be felt by the victims of negligent care who may need to go without compensation or with little compensation. In addition, relieving negligent doctors of responsibility for paying for their victims' injuries does not mean that these costs will disappear. Someone has to pay for these injuries. If it is not the negligent provider it is the victims themselves or public programs like Medicaid. This does not

save the country health care costs; it simply redistributes those costs from wrongdoers to innocent parties.

Finally, we think that restricting victims' rights could increase the cost of the health care system because it would decrease the deterrent effects of the system. Reducing deterrence could increase injuries, and likewise, increase health care costs.

It is really an insult to the millions and millions of people who are uninsured and underinsured in this country that the answer to their problem is to take away compensation from people who have been injured by negligent health care. This country does have the resources to provide both adequate health care to all of its residences and to adequately compensate victims of medical malpractice.

As you may know, Public Citizen is a strong supporter of a single payer health care program similar to the Canadian system to provide universal health care in the United States for the same costs as our current system, without curbing the rights of malpractice victims.

The solution to the serious problem of malpractice, on the other hand, is to prevent the injuries in the first place through improved doctor discipline efforts, better training and the adoption of medical practice guidelines.

Improvements in disciplinary programs against doctors who commit malpractice, we believe, could prevent a substantial amount of that malpractice from occurring. This is because, according to many studies that have been done, a small number of physicians are responsible for most incidents of malpractice. So that if you could reduce the occurrences of malpractice by those few providers you could significantly reduce the prevalence of malpractice in this country.

But that is not what is happening. The Public Citizen Health Research Group puts out every year an analysis of disciplinary measures taken by the various States. What we found in 1989 is that the rate of disciplinary actions among the States has actually decreased slightly. The average rate is 2.64 disciplinary actions per 1,000 physicians.

I would like to, if I may, submit for the record our latest report on doctor discipline.

Senator ROCKEFELLER. Of course.

[The report appears in the appendix.]

Ms. GILBERT. In sum, we believe that many innocent victims are injured or killed every year due to medical malpractice. The liability system is designed to compensate those victims and to deter physicians from negligent behavior. This system is not perfect. Too few victims are compensated through the courts and the incidence of malpractice continues at an unacceptably high rate.

But the answer is not to limit victims' rights in medical malpractice. We believe that is both misguided and a cruel solution. The only humane and effective mechanism for lowering medical malpractice costs is to limit the incidents of physician negligence and thereby lower the number of malpractice victims.

We look forward to working with Congress to both adopt a national health program and institute reforms that would reduce the incidence of medical malpractice and improve the overall quality of

health care. We will continue, however, to strenuously work against proposals that would make it even more difficult for victims of medical malpractice to recover for their injuries.

Thank you.

Senator ROCKEFELLER. Thank you, Ms. Gilbert.

[The prepared statement of Ms. Gilbert appears in the appendix.]

Senator ROCKEFELLER. Dr. Rydland?

STATEMENT OF DANINE RYDLAND, M.D., AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY, MARTINSBURG, WV

Dr. RYDLAND. Mr. Chairman and members of the subcommittee, this is not the first time that I have testified before the Senate on the issue of medical liability. When I previously testified in 1986 I was a practicing OB/GYN fulfilling my National Health Service Corps obligation in a medically underserved area, Petersburg, West Virginia.

I could not have imagined at that time that I would give up obstetrics 4 years later due to skyrocketing malpractice insurance premiums in West Virginia of all places. My malpractice premium was rising to $40,000 per year. Given the depressed economic situation in West Virginia, I refused to pass these costs along to my patients. They simply could not pay them.

By limiting my practice to gynecology my malpractice insurance is considerably lower at $17,500 per year. With all due respect, I would much rather be providing maternity care, as I have been trained to do, than to be testifying about the ongoing liability crisis which has caused many of my colleagues to quit obstetrics altogether.

According to a 1990 survey of ACOG membership, 12.2 percent of OB/GYN's nationally had given up obstetrics because of liability concerns and almost one-quarter had decreased the amount of high-risk obstetric care they provide. The same survey reported that almost 78 percent of our physicians had at least one claim filed against them. Clearly the liability crisis is not due primarily to the bad doctor.

If medical care was getting worse the liability crisis would not be surprising, but all indications for the last decade show better outcomes. Infant mortality rates are down; maternal mortality rates are down, yet the number of lawsuits is up.

In response to liability concerns we are witnessing a disturbing trend taking shape within the profession. OB/GYN's are giving up obstetrics at an earlier age. OB/GYN's used to phase out their obstetric practice as their patient population aged and switch to a gynecology only practice around the age of 55. Yet more than one-third of those who have quit stopped before the age of 45. It is clear that we are losing some of our most experienced and competent practitioners in the prime of their careers. I, myself, stopped practicing obstetrics at age 35.

The liability crisis is affecting family physicians as well. One-third of family physicians in California, whose practices included obstetric services no longer provide prenatal care. Almost 40 percent of Texas family physicians and approximately one-half of Nevada's rural family physicians have stopped delivering babies. It is

our patients, however, who ultimately suffer from the liability situation.

When I was practicing in Petersburg, I provided the only obstetric care for five eastern panhandle counties. A recent study by the Rural Health Research Center concluded that women living in rural areas who obtained their obstetric care outside local communities are more likely to experience adverse perinatal outcomes.

Enough statistics. Let me tell you what types of tort reforms we think work. It is vitally important to encourage alternative dispute resolution systems as you, Senator Durenberger, have proposed. The current system for compensating injured parties is time-consuming with average delays of 5 years before payment in OB/GYN cases. It is also inefficient with as little of 28 cents of each malpractice premium dollar going to the injured party.

The current system is unacceptable. Both patients and physicians suffer. We support tort reforms such as a cap on noneconomic damages; periodic payments of future damages; a shortened statute of limitations for claims by minors; and a mandatory collateral source offset. These are similar to reforms enacted in California where fewer of my colleagues have quit obstetrics according to 1990 survey.

The survey also showed a significant increase in the percentage of California OB/GYN's devoting at least one-fifth of their practices to high risk care. In addition, ACOG supports strengthening the State medical boards that are responsible for disciplining and removing physicians who provide substandard care.

In closing, the bottom line is that pregnant women in many areas of the country are having difficulty obtaining prenatal care. While it has never been safer for a woman to have a baby in the United States it has never been riskier for a doctor to deliver one.

I hope to take up obstetrics again when the liability climate improves. Towards this end, I urge you to pass Federal legislation. We cannot allow the situation to deteriorate further and jeopardize the health of American women and their infants. I hope that if I am called upon to testify 5 years from now it will be to tell you the positive effects your legislation has had on the delivery of obstetric care and not to tell you how much worse the situation has gotten.

Senator ROCKEFELLER. Thank you, Dr. Rydland.

[The prepared statement of Dr. Rydland appears in the appendix.]

Senator ROCKEFELLER. Richard Smith.

STATEMENT OF RICHARD I. SMITH, DIRECTOR, PUBLIC POLICY, WASHINGTON BUSINESS GROUP ON HEALTH, WASHINGTON, DC

Mr. SMITH. Thank you, Mr. Chairman, Senator Durenberger. I am Richard Smith, director of public policy of the Washington Business Group on Health. I appreciate the opportunity to testify today.

The Washington Business Group on health is an organization of large employers. It has been involved in public and private sector efforts to improve health care delivery and financing since 1974. In recent years we have devoted considerable attention to the malpractice liability system. We have done work with a number of or-

ganizations, including the Department of Health and Human Services. We have concluded that the current system is in need of fundamental reform.

I am not here today to argue that fixing our malpractice system will by itself dramatically improve our health care system's performance. While the malpractice liability system is on its own terms appalling, it is only one piece of the health system reform puzzle.

Often participants in the health system reform debate speak in shorthand. For example, they speak of play-or-pay, small group market reform, national health insurance, tax credits. We should not let this shorthand obscure the fact that the health care system is an extraordinarily complex organism which is driven by numerous perverse incentives, including the way we handle malpractice liability. It will take hard work to untangle this web of perverse incentives, but this work must be done because the big concepts can easily fail when they meet what happens in real life in the service delivery system. Malpractice liability reform provides a starting point.

Mr. Chairman, a brief overview of our critique of the malpractice liability system includes the following, much of which you have already heard from prior witnesses, so I will be very brief. First, there is little evidence that the current system effectively deters negligent care. Studies indicate that negligence rates have not dropped over time despite a dramatic increase in malpractice claims and costs. If we compare studies done in California in 1974 and in New York in 1984 we see roughly similar rates despite the much higher rates of claims and the much higher costs associated with the system.

Second, as we have already heard today, the system limits access to care and burdens community health centers.

Third, the system promotes defensive medicine. It is important to recognize that overutilization can profit providers. However, I think that Senator Durenberger appropriately pointed out that that is not the best way to frame the issue. A better way to frame it, and this was the intent of the statement in my written testimony, is that it can profit providers given the way most medical care is currently organized. The Mayo Clinic model is not the model that the great majority of providers are operating within today. There is an inappropriate profit motive for providers to practice defensive medicine given the way most medical care is now organized, in addition to the motive of protecting against litigation.

However, the phenomenon of defensive medicine does appear to be real, as demonstrated by the example of electronic fetal monitoring. A recent report notes that a Utah malpractice insurer requires physicians to use fetal monitors in all deliveries, after finding that failure to use them was a factor in the bulk of successful birth-related liability claims. Yet 2 years ago the Institute of Medicine reported that studies do not support fetal monitoring's effectiveness in reducing infant mortality or morbidity.

Defensive medicine is not only costly, it also harms patients. Fetal monitor use increases caesarean section rates and one study has associated higher malpractice premiums with higher C-section rates. C-sections produce more maternal deaths than vaginal deliv-

eries as well as unnecessary cost, pain and suffering. At a minimum, eliminating the need for defensive medicine sets the stage for broader efforts to reduce inappropriate care.

Fourth, the malpractice liability system is terribly inefficient, in large measure because it does such a poor job of distinguishing meritorious cases from nonmeritorious cases. It does a very poor job of deterring the filing of nonmeritorious cases and a very poor job of weeding them out before they go to trial. Success rates for plaintiffs at trial are much lower in the malpractice liability context than in other civil tort actions.

Finally, the system is inequitable in a number of ways which have already been identified by prior witnesses.

In the interest of time I will only briefly identify a few of the characteristics which reform legislation should have. My written testimony goes into greater depth on this topic. Before identifying these characteristics though, I will note that the present system's few defenders often cast the debate in terms of victims' rights. We believe this distorts the issue. The present system does a poor job of vindicating the rights at issue by any measure. In addition, malpractice reforms have been upheld by many courts and Congress has chosen to modify how civil actions are handled in a number of areas of law when there has been a compelling public policy reason to do so. The poor results generated by the current system make the case for solving the system's problems rather than focusing on a single conception of rights.

In WBGH's view some of the characteristics reform should have include the following: First, it should be comprehensive. It should cover all potential targets and theories of liabilities. In this connection we note the need to be cognizant of evolving theories of employer and insurer liability in managed care settings, and the need to address medical equipment and pharmaceutical manufacturer liability.

Second, reform should replace the current system with alternative resolution mechanisms, principally fault-based, designed to speed up claims resolution, bring greater expertise and consistency to fact finding and decisions, and reduce transaction costs. We believe that this can be one element of a program that will reduce the incidence of negligence.

Third, reform should eliminate double recoveries. The method chosen though should carefully allocate the remaining recovery between the negligent provider and collateral sources.

Finally, Mr. Chairman, poor quality, inappropriate and expensive medical care is partly the result of our fragmented medical care delivery system. Our fragmented medical care delivery system lacks even basic quality improvement tools, such as a single medical record for patients. The fact that we must rely for data on the incidence of negligence on one study of cases that moved through New York hospitals 7 years ago is appalling.

The system should routinely generate the kind of data that would allow one to find out where malpractice is occurring and what needs to be done to correct it. As health system reform proceeds, it is vital that we create strong incentives for a fundamental reorganization of our inefficient fragmented delivery system into competing organized systems of care. This proactive strategy will

produce far greater benefits than consigning quality improvement solely to a redesigned malpractice liability system.

And finally, Mr. Chairman, malpractice liability reform itself should be used to promote the transition of our current inefficient and fragmented system into organized systems of care.

Thank you.

Senator ROCKEFELLER. Thank you very much, Mr. Smith.

[The prepared statement of Mr. Smith appears in the appendix.]

Senator ROCKEFELLER. Dr. Rydland, can I just start with you? You mentioned the fact that you came to testify 5 years ago but it was not, I believe, before this committee. I think this is the first time the Finance Committee has ever had hearings on malpractice reform.

Am I generally correct in saying that 3 or 4 years ago about 250 OB/GYN's were practicing in West Virginia and that today it is somewhere between 50 and 55?

Dr. RYDLAND. That is correct.

Senator ROCKEFELLER. Let me ask you why you think that is.

Dr. RYDLAND. We have had an exodus of obstetric providers. We have also had people retiring at an earlier age or dropping the practice of obstetrics. A lot of it has to do with the high cost of liability in West Virginia.

At one point Senator Durenberger was talking about the raise in malpractice premiums. At one point from 1 year to the next my premium rose 300 percent. And in the last 6 years my premium has done up 900 percent. At one point for a patient with Medicaid I was making $40 for 9 months worth of care after I paid my liability premium and 80 percent of my obstetrics patients were Medicaid. State-wide it is between 50 and 60 percent.

Physicians are not making money. There is at this point almost an adversarial relationship between patients and physicians that has developed as a result of this. Obstetrics has to be fun and at 3:00 in the morning if it is not fun, it is not worth doing. I think that a lot of physicians have decided that over the course of the last few years. We have taken all of the fun out of it.

Senator ROCKEFELLER. You indicated or rather I indicated before that about 2 or 3 years ago there were in fact 250 OB/GYN's practicing.

Dr. RYDLAND. There were.

Senator ROCKEFELLER. So presumably the tort system was the same then as it is now. What is so different about the last 3 years that has caused this enormous change? Incidentally, do you find this to be unique to West Virginia in conversations with colleagues or not?

Dr. RYDLAND. It is worse in West Virginia than it is elsewhere. I have been on the National Advisory Committee for rural health policy for the last 3 years. So I have had a chance to talk with people all over. It is a problem everywhere. It is particularly difficult in some of the frontier States and West Virginia in a lot of ways is the same as some of the frontier States, like the Dakotas and Montana.

One of the things that happened when I came 5 years ago, West Virginia had just passed malpractice legislation. The insurance companies all decided that under those terms they would no longer

provide liability insurance in West Virginia for physicians. The legislation was repealed as a result of that and rates have gone up astronomically.

Physicians will not come to West Virginia because they have heard about what is going on there. We cannot attract new physicians to the State of West Virginia. So those that are retiring or choosing to drop their obstetric practices are not being replaced.

Senator ROCKEFELLER. What happens to pregnant women? What happens as a result of this?

Dr. RYDLAND. Pregnant women are traveling further for their care. There are more of them that are not getting any prenatal care.

Senator ROCKEFELLER. In other words some get it but have to go further to get it, as opposed to those who just decide that they are not going to get it because they do not want to go for it.

Dr. RYDLAND. Sometimes it is not a matter of want. It is a matter of not being able to get there.

Senator ROCKEFELLER. Not having transportation?

Dr. RYDLAND. Correct.

I think more are traveling further for care. Therefore, they are going less often. And as some of the studies show the further that they go for care the higher the risk of problems with the pregnancies, premature deliveries, which again adds to the expense of the whole system.

Senator ROCKEFELLER. Did you find that you were either now or before, before you made your decision to get out, that in the period before that or whenever, that you found yourself practicing what has been called defensive medicine to protect yourself from the possibility of suit?

Dr. RYDLAND. I think that we do a lot more documentation nowadays. We do a lot more testing. Fetal monitoring has become routine, where it was not in the past, and the studies do not always bear out that that is necessarily better.

The cost of care has gone up because we order tests that we did not used to order because you have to cover all your bases. The judgment of the physician is not taken into account anymore. The art of medicine is being lost and the science is being emphasized.

I think that there has been a change in practice patterns driven by the liability crisis, yes.

Senator ROCKEFELLER. West Virginia is not the biggest State in the world, but there are 1,800,000 people who live there; we have 55 counties. We have many counties without a practicing OB/GYN.

Dr. RYDLAND. That is right.

Senator ROCKEFELLER. And a number of those do not deliver and within that a number of those do not deliver Medicaid babies.

Dr. RYDLAND. That is correct.

Senator ROCKEFELLER. What happens? What happens at the time of delivery?

Dr. RYDLAND. When I was in Petersburg I had patients that delivered in other hospitals in the emergency room by the internist. I had a patient who lived 20 minutes from Cumberland, MD, who was denied care because she had West Virginia Medicaid. So she came to me 2 weeks after her due date with a severely distressed

baby because she did not know that she could get care an hour and a half away where she was denied that care 20 minutes away.

It makes providing care much more difficult for those who still provide care because we are presented with what we call train wrecks because people are not getting care and are not preventing. We talked about preventive medicine. That is what prenatal care is all about. If you cannot prevent the problems then you have to deal with the problems that drives up the cost of care, you have more premature babies, you have more problems.

Senator ROCKEFELLER. Is the nurse midwife stepping into this gap, Ms. Fennell?

Ms. FENNELL. We can only step in to a certain extent. In the State right now, you have less than 40 nurse-midwives. The College requires in the standards for practice that in order to keep your certification to practice, you must have a backup physician to collaborate and refer patients so that women who develop complications requiring physician care, that it is relatively available so we do not have the case of the woman who we just talked about who did not get care.

The other thing that is happening in West Virginia is the University and the School of Nursing at Charlestown will be opening up a nurse-midwifery service within the next few months. Once the service is well established, within another year we will have a school of nurse midwifery there.

We hope that some of those initiatives will assist the obstetricians in the State.

Senator ROCKEFELLER. In your experience, Dr. Rydland, you practiced as a National Health Service Corps. You now practice in the Martinsburg area.

Dr. RYDLAND. That is right.

Senator ROCKEFELLER. Which I assume covers a rather large area.

Does the nurse midwifery growth potential help out in this crisis in your judgment?

Dr. RYDLAND. Without nurse-midwives we would not be able to provide the service that we are presently providing. In Martinsburg there are three physicians providing obstetric care and three midwives. We provide care—I should say they since I do not do it anymore—for roughly 1,000 pregnant women a year coming from Berkeley, Morgan, and Jefferson Counties.

Without the midwifery services the physicians would not be able to provide prenatal care for the numbers that they do.

Senator ROCKEFELLER. Do patients—and I would ask both of you this—expect different things from a nurse midwife as opposed to an OB/GYN, a different level of care or what?

Dr. RYDLAND. I can address what we are doing in Martinsburg. Most of the prenatal care is provided by the midwives and the delivery itself is provided by the physicians. Our midwives have not been able to spend as much time in the hospital because they are providing prenatal care for 6 hundred and some women a year. So we work together and provide the care and the level of service, I think, is the same.

Ms. FENNELL. We see a lot of this, in West Virginia, the co-management situation of women. We do have some new providers in

the State, some family practice doctors and nurse-midwives who are actually substituting for one another, where the nurse-midwives are doing the delivery for the essentially normal woman.

Senator ROCKEFELLER. Could I then—and Senator Durenberger I will stop and come back after you question—make the logical assumption that what you are saying, Dr. Rydland, is obviously true about OB/GYN's practicing but that potentially the 40 nurse-midwives that Ms. Fennell is talking about is beginning, in fact, to make up that difference. So that your complaint may be personal within your profession but as far as the patient is concerned the patient may be as well served by a combination of OB/GYN's and nurse midwifery?

Dr. RYDLAND. I think that collaborative practice is important. It is the only way to provide care when the numbers are so limited. I think that as far as high risk care is concerned women are having to travel further. Again, between Martinsburg and Morgantown there may be one place they can go if they are high risk. And they cannot be taken care of in their local communities because there is not a physician capable of taking over that care.

So the midwifery program is filling some of the gap and it is preventing some really bad things from happening. But it is not solving the problem.

Senator ROCKEFELLER. And in Petersburg, for example, you said there are three OB/GYN's, three nurse-midwives working together in the Martingsburg area.

Dr. RYDLAND. In Martinsburg.

Senator ROCKEFELLER. In Petersburg, and for the sense of our audience, that is a much more remote community, are the nurse-midwives also available?

Dr. RYDLAND. In Petersburg a National Health Service Corps physician took over for me 4 years ago. About 6 months or a year ago he also added a midwife and now there is a semi-retired obstetrician from the D.C. area who comes out one week a month to cover for him.

They are still providing care for five counties and in the winter time that can be a real trip as you well are aware.

Senator ROCKEFELLER. Thank you.

Senator Durenberger?

Senator DURENBERGER. I want to thank all of you for your testimony.

Mr. Smith, thank you for your statement, your comprehensive review of S. 1836 and your support for it as well.

I would say to the Chairman, the Chairman has been very generous. When we were on the Pepper Commission we had an experience in Minnesota with a couple that delivered a baby. The baby ended up dying because they could not get into the hospital and so forth. He has been generous enough to use the Minnesota experience. I am going to recommend to him a two-sentence closing from a West Virginia, that he think about as he thinks about the whole issue of the need for medical liability.

That is, it has never been safer for women to have a baby in the United States today; and it has never been more risky for a doctor to deliver one, which is really something for all of us to think about.

Ms. Gilbert, thank you for pointing out to us that if we are looking at access and cost we have a lot of places we can look at in the system today and the self-referral discussion we had earlier is a part of that problem. I think what I tried to do is, my comments about Senator Daschle's question is to indicate that there is a trend in medicine towards changing the way medicine is practiced in which you may see profit, but you may see that profit shared across a variety of specialties and expertise just as profitability in healthy babies may be shared between the mid wifery an OB/GYN and some nurses and a variety of other people as well.

So the failure in the system does not come automatically because a physician may have an interest in some other part of the process. It is the way that whole process is organized, so that everyone can share the responsibility for the outcome. That seems to be one of the shortcomings we all face in this process.

Ms. Fennell, my question of you is, as we look at the cost this system is imposing on us, it is possible to sort of blame that on insurance companies because it is insurance companies that evaluate the potential of the cost and then translate that into premiums. But as I understand it, now about 45 percent of all of the malpractice insurance that is written in this country is being written by physician organizations, something close to a self-insured model.

You were generous in going through a variety of efforts that you had undertaken as a national association to find and insure. Is there a reason why the Association or all people engaged in the profession do not form an organization to self-insure?

Ms. FENNELL. Our numbers are not great enough to self-insure. At least that is what our advisers are telling us. And the physician-owned companies that we have approached have had no interest in insuring nurse-midwives.

Senator DURENBERGER. Have no interest in?

Ms. FENNELL. No interest in insuring us. I do not believe that has to do so much with the obstetrical population. You have to remember these are the same companies that are imposing upon the obstetricians and family practitioners these surcharges, with no data to support them.

Senator DURENBERGER. With no data to support them?

Ms. FENNELL. To support them.

Senator DURENBERGER. I wonder, Ms. Gilbert, if you could not help us understand a little more the objection that your organization has to elements of reform. I stated earlier as an author of one of these approaches I stated my objectives which were (1) to better define quality; and (2) to ensure a remedy whenever there is a failure in meeting those objectives.

All of the data that studies seem to offer us say that the present system which is largely a tort based system is not doing either. I think one of the earlier witnesses says it keeps pushing our definition of quality to whatever new invention comes along and so forth. Which reminds me of why I do not support a single payer system, because if you made all the Canadian health care system live by the U.S. malpractice standards everybody out there would be guilty of malpractice.

But the point is, can you be more specific about what it is in the reform that you believe would decrease the number of victims who

are currently receiving compensation for injury? I mean I understand now it is something like 3 percent of all victims get compensation or some very small figure. And you, I take it, if I take your statement literally, that would be reduced by any of these reforms. Could you point out for us which of these reforms would do it and how it would accomplish that?

Ms. GILBERT. I have to say that I am not familiar with your proposal. So what I may address may not be in what you are advocating.

Senator DURENBERGER. That is fine.

Ms. GILBERT. I certainly agree with the goals that you just stated in improving quality and ensuring compensation. What we have looked at have been the proposals that have been put forward by others for supposedly fixing the malpractice system, like caps on damages, offsets to the collateral source rule, statute of limitations provisions.

Many of them focus on damages, caps on damages. For example, as far as I can see, that is not going to change what seems to be the biggest criticism of the system—that it is inefficient, it is not compensating negligently injured victims. Both criticisms we agree with. But capping damages is going to do only one thing, and that is reduce the damages that the most seriously injured victims can collect today.

Every study that has ever been done shows that the most seriously injured victims are the ones that are undercompensated in our tort system. A cap on damages, particularly the ones that have been proposed, are generally something like a $250,000 cap. Only the very, very most seriously injured victims ever receive anything more than $250,000. It is extremely rare.

But for those people, those are often the permanently injured, people who may require millions of dollars in medical care. Why are we focusing on those vulnerable and very unfortunate victims as the people we are going to take money from in order to fix the rest of the system?

Senator DURENBERGER. Is it likely to presume that it is the few awards in excess of $250,000 that many insurance companies use to predict premiums and therefore it is a few of those awards that are setting the standards for premiums?

Ms. GILBERT. It could be. It is very difficult to know what the insurance industry is using to set their predictions and their rates. When I listen to this panel, and I could not be more sympathetic and concerned about what has been said from the doctors on this panel and nurse mid wives, that is a very, very serious problem for consumers if you cannot get obstetrical care.

It looks to me like we have a serious insurance problem. Why are insurance rates, especially now when supposedly the crisis is over and insurance rates for most physicians are going down, why should obstetricians in West Virginia have a 900 percent insurance rate increase over the last 3 years. That is an outrage and that is something that has to be looked at.

There is a wonderful study that was done by the Pennsylvania Trial Lawyers in conjunction with the Pennsylvania Medical Society. They looked at the insurance crisis in the State of Pennsylvania. They concluded that what the medical malpractice system

needs is experience rating. That the doctors and the hospitals—and Dr. Brennan said this earlier—should be assessed insurance premiums based on their own experience.

The insurance industry has that information. Why they are not using it to better set their premiums in a more rational way we have no idea. But we think that would be the correct solution.

Senator DURENBERGER. You would have no problem with experience rating insurance premiums?

Ms. GILBERT. That is what we would encourage—more experience ratings.

Senator DURENBERGER. Okay. Thank you.

If my bill had in it a cap on so-called non-economic damages of $250,000 that you would find objectionable?

Ms. GILBERT. Very objectionable.

Senator DURENBERGER. And if my bill had in it mandatory offsets for damages paid by collateral sources you would find that objectionable?

Ms. GILBERT. Yes, the way we have seen it described usually.

Senator DURENBERGER. If my bill had in it mandatory periodic payments of awards exceeding $100,000 as a replacement to the lump sum awards, would you find that objectionable?

Ms. GILBERT. Yes, because it is mandatory.

Senator DURENBERGER. Why would that one be objectionable?

Ms. GILBERT. We think periodic payments is often the right way to go and it is very appropriate. It happens very often in court today. But it should not be mandatory. There are some situations for certain reasons that a victim requires a lump sum up front.

Senator DURENBERGER. If my bill were to provide for limitations on attorney contingency fees, like 25 percent of the first $150,000, 15 percent over that, would you find that objectionable?

Ms. GILBERT. Yes, we would.

Senator DURENBERGER. And why?

Ms. GILBERT. There has been no evidence that has been shown to us that limiting contingency fees does anything to increase the efficiency in the system or increase the number of malpractice victims who are being compensated or being adequately compensated.

Contingency fees should not be out of line and that should be a matter that is negotiated between an injured person and their attorney just as defense fees should be negotiated between the doctor and their attorney. I do not think defense fees should be limited and I do not think plaintiff's fees should be limited. That is something that I think the market place should take care of with some adequate oversight by each State Bar.

Senator DURENBERGER. And you know that that sort of makes you sound like attorney watch rather than Congress.

Ms. GILBERT. Well maybe. Then a lot of times what is said by the American Medical Association makes them sound like the American Insurance Association.

Senator DURENBERGER. I understand that.

Ms. GILBERT. But you look at the issue and decide based on who you are representing what you think the best solutions are. I do not care very much about lawyers, how much money they make. It is not anything I ever look at or spend a lot of time worrying

about. What I care about are the clients of those lawyers—injured victims—and being able to get into court.

It seems to me limits on contingency fees are proposed for one reason, that is to keep some victims out of court.

Senator DURENBERGER. And the California experience is not instructive in this regard?

Ms. GILBERT. Well I have not seen adequate data on the California experience. The studies I have seen of tort reforms in general that have been implemented show that those tort reforms have not improved the medical malpractice system.

Senator DURENBERGER. If I have joint and several liability for noneconomic damages in my bill, would that be objectionable?

Ms. GILBERT. Yes.

Senator DURENBERGER. And if I started limiting the statute of limitations in any way, would that be objectionable?

Ms. GILBERT. It depends how it was limited, I suppose.

Senator DURENBERGER. And if I were to go after the notion that all punitive damage awards would go directly to the plaintiff rather than perhaps some part of it going into a special trust fund to assist States in the improvement of health care quality programs or something else, would you find that objectionable?

Ms. GILBERT. I would have to look at that proposal.

Senator DURENBERGER. Because I think various bills have various proposals for what you do with punitive damages.

What is your view on alternative dispute resolution?

Ms. GILBERT. We are big supporters of alternative dispute resolution processes. We like them to be voluntary. There needs to be much more experimentation with them. You know, some of the ADR provisions that have been implemented around the country actually increase costs because they increase the number of people who are being compensated. I do not object to that. But you have to figure out what your goals are and then how to implement them.

But alternative dispute resolutions are something that we have endorsed for a long time.

Senator DURENBERGER. In the proposal that I introduced yesterday undertaken to include the medical products, drugs, devices and so forth, along with the professional liability, is that a good idea or not so good idea or does it depend on how I do it?

Ms. GILBERT. We are opposed to any kind of Federal limitations on product liability cases, whether it is medical products or otherwise.

Senator DURENBERGER. And that is laid on the same premise as your others, which is that implicit in all of that is limitations on awards, limitations on access to the tort claim system?

Ms. GILBERT. Exactly. Making it more difficult for injured victims to get compensation through the courts.

Senator DURENBERGER. So then just as a bottom line—this is my last question—what reform, if we accept the current system with some very small percentage of injured people being compensated and we accept the current system in which 56 percent of the money involved in trying to compensate them actually does so, what is the reform that you offer that would guarantee us that 100 percent of the people would be compensated?

Ms. GILBERT. I do not have a reform for that. We think we need to reduce seriously the number of malpractice victims and the incidents of malpractice in this country. There needs to be better doctor training, doctor discipline, a great deal of emphasis on prevention and loss prevention. It is what my organization in the product area and in the medical care area has been devoted to for many years.

We also think there is a serious problem with the insurance practices in the medical malpractice area and the product liability area. We need some good, solid insurance reform to get these insurance premiums down.

Senator DURENBERGER. Well I would just close with an observation on that and that is that you have heard from the witnesses here today and there are many more that we have heard traveling around the country on the Pepper Commission and on our own, that while Congress watched with all the public confidence that it has and its positions, has been advocating the reforms you have suggested and objecting to the reforms offered by others, the situation keeps getting worse in terms of fewer people getting access to much needed prenatal, natal, postnatal care.

Just to give you one example, the situation keeps getting worse. The record is that this system is not working and each time somebody offers up a solution of some kind, that is that suggests that you are moving in the direction of more universal reform, there is a response that says somehow this is provider motivated. That is the one I usually gets. It is provider motivated.

You know, look at your list of supporters. They are all providers and so forth or provider oriented. So it is a frustration to try to be a reformist in this particular area because the situation just keeps getting worse.

Ms. GILBERT. And that is the case even though every State in the country has passed some kind of supposed reform to their legal system in the medical malpractice area. I agree with you that the problem is getting worse. Where we disagree is on the offered solutions. We think there are solutions. Making it harder to receive compensation through the courts is not it.

Senator DURENBERGER. Well I know my State, I think it was 1986, passed some reform and within minutes the trial lawyers who had been asleep at the switch in 1986 got back in there and within 2 years they changed it. You know, for the sake of unlimited damages and that, they decided to undo the reform.

This keeps happening all over the country. I think California is big enough so that it has not happened in California. I am not antilawyer. I mean, thank God they are around. But all of the evidence says that somehow we are all going to have to alter some of our thinking on this subject or it is just going to get worse.

Mr. Chairman, thank you.

Senator ROCKEFELLER. Thank you, Senator Durenberger.

Mr. Smith, in your testimony you indicated that medical liability reform must be linked to organized systems for the delivery of care. I understand the words. I do not understand what you mean.

Mr. SMITH. Senator, medical liability reform can proceed independently of comprehensive health system reform. There is a compelling case to proceed with malpractice reform now. Any reasona-

ble set of reforms will improve the current situation. However, the Washington Business Group on Health's position is that all aspects of health system reform that are proceeding now ought to be focusing on the reorganization of health care delivery into organized systems of care.

Reform of malpractice liability law is one sort of reform that can be used to drive the system in a direction which we believe can produce higher quality, more appropriate care.

Senator ROCKEFELLER. Okay. Thank you.

Ms. Gilbert, you heard Dr. Rydland and I recognize that there is, and I think I have indicated, that there are many more patients who were harmed than who file suit. But, nevertheless, this study indicated that 78 percent of practicing OB/GYN's have had at least one liability claim against them.

You do not live in West Virginia. You do live here. You have a lot of health care available to you in a very rich city, for most people. It is not wealthy for its very poor, but you are not one of them. You have been struck, I think, by what happens when people stop practicing medicine.

It is not just OB/GYN's that has devastating affects. It is also emergency doctors. Sometimes they stop because they are getting the most extreme cases. In many cases their emergency rooms and trauma centers are simply closed down. It is the first thing to be closed down, in fact, by most hospitals because it is the most expensive.

Neurosurgeons, there is a terrible effect on them and often they simply cannot practice because of medical liability.

You say well we have to do something to the insurance companies. I am very much for that. I want to take them back to community rating like we did with Medigap. But very few people indicate that if you reform the insurance companies that in fact you are going to lower the cost of health care very much at all. That you may stop the increase. There are not very many that will testify that you will lower the cost.

Generally speaking, I mean I understand what you want to do, you want to protect victims. But you do so primarily really just by obstructing any change. You simply, your organization sets out sort of militantly to deny any change in medical liability, tort reform, whatsoever on the theory that if there is any change it is not going to benefit anybody but greedy doctors and bad people who do awful things.

I understand the need for extreme positions in order to influence legislation properly. But do you not agree that there is a rather enormous problem out there, that there are 37 million people who do not have any health insurance, that the single payer health care system that you say is the answer is probably not going to happen at once. Therefore, you have to deal with people in the present circumstances.

So the question is, do you hold hostage people who cannot get health care in West Virginia because they do not have the transportation to go to the distant OB/GYN for prenatal care? Do you hold them hostage simply so that you can go home each night aware and pleased that you have prevented anything from happening in tort reform?

That is not a particularly pleasant question, but I do address it to you.

Ms. GILBERT. There are a lot of questions there. We are interested in reform of many systems that we have. We are not interested in and we will never endorse and will always oppose changes that are simply intended to make it more difficult to receive compensation through the court system. That is what we often come before panels like this to talk about because that is the proposal that is put on the table. That is not what we would prefer to spend our time doing.

But the problems are very, very real. All of the problems that have been identified here today are very real. We do not think that the solutions that have been offered are going to address those problems at all. In fact, we think they might make them worse. So to say that, because of that view, we are merely obstructionists I just do not think is the case.

We have a great deal of positive proposals for improving access to health care, for improving quality of health care, for improving the ability of physicians and others to obtain adequate insurance and we would be more than happy to talk about ways to get more people compensation.

Now if we do that we probably will not reduce costs. We might add to costs. The issue of medical malpractice and victims of malpractice is inappropriate in many ways in the context of increasing access to health care and reducing the costs of health care. Because if we really want to look at the issue of malpractice victims as it has been identified today, most of them are not being compensated.

We care about that a lot and want to talk about ways to get more compensation to those people. I think it is going to be more expensive to do that. I think it still should be done. But that is a very different issue from access to health care, reducing costs. We think the best way to reduce costs in the system—up to 25 percent of those costs—is to get rid of the administrative costs of the health insurance system. That again is a different issue.

So we have a lot of proposals we are more than willing to talk about. But what we do not think is going to work and what we will always work to defeat are proposals that put reducing costs on the backs of the most seriously injured victims, the people who are the victims of malpractice and are the ones that are using the legal system.

Our legal system is inefficient. Again, we are interested in increasing the efficiencies of that system. But unfortunately, we recognize that just as our democratic system of government is inefficient, our legal system and jury trials are going to be somewhat costly and inefficient to ferret out the truth in those trials just as the democratic process is somewhat inefficient but it works very well to represent the interests of the people.

But we are interested in making the legal system more efficient. We are interested in compensating more victims. And we are certainly interested in improving access to and the quality of health care. But we oppose efforts that will make it harder for victims to recover losses.

Senator ROCKEFELLER. In that you object to change in the current tort reform system, what is the evidence that you would submit to

this committee that the current system, in fact, deters negligent behavior on the part of physicians?

Ms. GILBERT. The studies that have been done by the Rand Institute, Dr. Brennan who spoke this morning, the Pennsylvania study that I mentioned before. All have found that, although difficult to quantify, that the medical malpractice system does deter malpractice to a certain extent. Patricia Danzig, from the Rand Institute, I think, has estimated that 10 percent of malpractice is deterred through the medical malpractice system.

I thought also very interesting was Dr. Brennan's proposal this morning for improving the quality of care through the insurance premiums of hospitals. That hospitals that improve their quality of care and set systems in place would have their insurance premiums decreased and the contrary for hospitals that do not do that.

That is what the tort system is supposed to do. The insurance rates are supposed to be reflective of whether you have many liability claims before you and insurance companies should be doing that today, getting involved in risk management of doctors and hospitals. So for Dr. Brennan to suggest that that is what ought to be done says to me that there are deterrence mechanisms if used properly in the system that could work.

Senator ROCKEFELLER. In that 200 of the 250 doctors, I mean OB/GYN's, in West Virginia who were practicing 2½, 3 years ago have quit practicing and Dr. Rydland indicates that a good deal of that comes from the cost of and fear of malpractice, what comfort, if any, is there in that fact to you?

Ms. GILBERT. No, I am very troubled by it and I think that we need to look at the practices of the insurers in West Virginia. I think she said that her rates went up 900 percent in 3 years.

Ms. RYDLAND. Six years.

Ms. GILBERT. In 6 years, I'm sorry.

If your claims went up 900 percent in 6 years what possibly could have caused that.

Senator ROCKEFELLER. Dr. Rydland, what is your response to the difference between health insurance premium costs in your decision and others decisions as opposed to the fear of medical liability.

Dr. RYDLAND. My insurance company does do some basing their premiums on whether or not there have been suits. The reason my insurance premium is not higher is because I have not been sued. I think that the costs do make a major difference as to whether or not people provide care.

I also think that the adversarial relationship that has been developed by the tort system between the patient and the physician. The physicians are afraid that patients will sue and do everything possible to eliminate that.

Yet we have——

Senator ROCKEFELLER. Now, see, Ms. Gilbert would say-what you have just said is the reason that she does not want to change the system. The physicians are afraid and, therefore, they are going to do everything possible not to get in trouble. She would say you have just made her case.

Dr. RYDLAND. In our College we do everything we can to assure that we are providing quality of care. In order to be a member of the College you have to be Board certified, which is a 2-year proc-

ess after a 4-year residency program. You have to continue with recertification examinations in order to stay licensed. You have to get continuing medical education credits. The insurance companies and the hospitals are doing risk management and quality assurance is a big issue in hospitals in medical societies, and yet even though we are trying to police ourselves and we are trying to assure the best quality of care sometimes things happen that are outside of anybody's control.

For the physicians to feel that we have to do things that have no impact on quality of care because of liability exposure increases costs, it creates an atmosphere where physicians do not want to practice. I did not go into this to spend all my time trying to decide whether legally I need to get this test. I went into this field because I wanted to take care of patients and I want mommies and babies to do well.

With the current environment that is not what we are doing.

Senator ROCKEFELLER. Dr. Rydland and Ms. Gilbert, people have very high expectations in America, and people have extraordinarily high expectations of medicine. In fact, I think it would probably be safe to say that people assume that as a matter of right that babies should be born perfectly, that cancer should be cured perfectly, et cetera.

How would each of you respond to the question of the high expectations of patients with respect to medicine and the relationship of that to the instinct to sue if perfection is not achieved?

Dr. RYDLAND. I think that is part of the problem with the system as it stands. Everyone does expect a perfect baby and everyone expects that if you have a surgical procedure that everything will go well no matter whether or not there is a risk of infection from a Caesarean or bleeding or whatever. Everyone, even though you explain those things, and sit down and spend 20 minutes or a half an hour explaining all the risks of a procedure, if something bad happens, they still think that there should be compensation.

We do everything we can to minimize the risks and we do everything we can to explain to people that sometimes bad things happen. If you provide the best possible quality of care sometimes something is still going to happen. In obstetrics it has just gotten to the point where it is difficult just to be there because of the threat of being sued.

Senator ROCKEFELLER. Ms. Gilbert?

Ms. GILBERT. I think it is a shame that there is this perception out there that there is an instinct to sue in this country. That is something that maybe my organization needs to go out and try to work against, because that is not the facts.

The Rand Institute's most recent study of injured people found that 3 percent of injured victims, if they are injured not in the work place and not by automobile accidents, that would include medical malpractice victims, only 3 percent ever even bring a claim. That is not how many people ultimately get compensated through the system; about half of those do not succeed in their claims. Only 3 percent of injured people ever bring claims.

When the injured people that the Rand Corp. surveyed were asked, well, why did you bring a claim or not bring a claim, the answers were they brought a claim when their injuries were very

serious and were not compensated elsewhere, and where they believe their injury was caused by another party.

I think that is very rational thinking on the part of the American public and I think if we wanted to create a legal system that is what we would create it for, for people who need the compensation and believe that someone else caused their injury so that person should pay the compensation.

So that it is really not an irrational system as it is portrayed and it is not used very much for compensation by injured victims, whether it is in the medical malpractice context or elsewhere.

Senator ROCKEFELLER. That was not the question I asked. The question of the expectation of perfection on the part of people in this country about medicine, would you grant that that is a factor?

Ms. GILBERT. I do not know. I do not know about that. I am not an expert on that.

Senator ROCKEFELLER. You mean you never thought about this in your life?

Ms. GILBERT. No. What I am knowledgeable about is how that expectation may or may not lead someone to bring a lawsuit. Where there is an expectation of perfect medicine is something that I have not had an opportunity to know. I did not get a lot of medical care in my life time and I do not know.

Senator ROCKEFELLER. I will not probe on that then.

Seventeen percent of all physicians in this country are in primary care. I would guess that means that doctors, or potential doctors in medical school, are making the decision not to go into primary care, which is the essence of preventive medicine, which everybody has been talking about, because there is no money there or there is insufficient money there. People, of course, always make the assumption in this country that all doctors are millionaires and that is not the case. It is particularly, of course, not the case with primary care.

One of the reason that people cannot make money in primary care is because they have this perception that they are going to have very high malpractice premiums and physicians seem to keep saying that. In fact, Dr. Rydland is saying that. Isn't there something wrong in a country in which only 17 percent of the physicians by their own choice are involved with primary care? The very branch of medicine which has the most to do with preventive care.

Ms. GILBERT. Yes, I think it is an insurance problem. I think the insurance rates are too high and the insurance premiums are not set correctly.

Senator ROCKEFELLER. I thank all four of you very much. You have been very patient, maybe not as patient as the last panel, but nevertheless very patient and very helpful.

Thank you.

Ms. GILBERT. Thank you, Senator.

Senator ROCKEFELLER. The last panel consists of Randall Bovbjerg. You will have to tell me if I have mispronounced that. He is from the Health Policy Center at the Urban Institute. And Robert McAfee, who is from the Maine Medical Association, and is vice chairman of the board of trustees of the American Medical Association.

Mr. Bovbjerg?

STATEMENT OF RANDALL R. BOVBJERG, J.D., SENIOR RESEARCH ASSOCIATE, HEALTH POLICY CENTER, URBAN INSTITUTE, WASHINGTON, DC

Mr. BOVBJERG. Thank you very much. It is, indeed, a pleasure to be here. I appreciate your concern about my name, Senator Rockefeller. The name is pronounced Bo-berg, like iceberg. Perhaps your colleague from Minnesota would have been more used to a Scandinavian name.

Senator ROCKEFELLER. I practiced actually before the hearing, but I failed.

Mr. BOVBJERG. Near Dead Coon Lake in Minnesota they would probably know how to pronounce our family name; that is where my grandfather grew up on a farm. But I guess the quality of his farming or his farm was not up to snuff because he ended up as a teacher in Chicago.

At any rate, Senator, please let me make four points this morning. The first is to discuss problems in medicine and law and more especially in their interrelationship.

Second, we need to talk about the limitations of tort reform and other alternatives that are done in a conventional way. This point has come up already this morning a couple of times.

Third, consider the promise of alternative systems that emphasize better care and prevention of injury. Again, this has already come up. It is fitting that Dr. McAfee and I are up here together. Both of us are speaking to alternative systems that attempt to put more science into the prevention of injury and to seek better medical quality in advance of disputes. Most other discussion is about dispute resolution, not prevention.

Finally, let me urge support for experimentation on the part of Congress, and for greater involvement of Federal health plans in more active quality and injury monitoring.

We are all here today because of perceived problems in the liability system. There is no current "crisis" despite the mention of higher insurance premiums for individual doctors. In general, premiums have gone down across the country in the late 1980's. The crisis atmosphere may soon return, however. There is already an upturn in claims, and premiums will follow. Whatever the insurance situation, moreover, there remains a sense that these medical-legal systems are not doing what we would like them to.

Fortunately, it is possible to speak to all of these problems from a much better knowledge base today than was the case in earlier hearings. There is a much more solid research base on medical, legal, and insurance issues. I have to get in a plug for a book that has just come out—"Insuring Medical Malpractice," from Oxford University Press, and the issue of "Law and Contemporary Problems," Duke University. The latter has articles by many of the people you have heard from and many others that you have heard referred to. I have left copies with the committee staff, one for each side.

My main message about problems is that only two big problems are really worthy of your attention. A lot of little problems exist, but there are just two big ones. They both come from interrelations of law and medicine.

The biggest problem is that very many more people suffer avoidable medical injury than any system takes care of, that is, any system that is supposed to promote quality or compensate injuries. A second major problem is that medical practitioners engage in some amount of defensiveness. This is raising health costs or reducing access to care. This is not unique to medicine, but it applies with particular force there because of the socialization of all these costs through health insurance. As will become clear. I think that this defensiveness needs to be attacked directly. It is not enough to attack it in directly by saying, well let's rein in the lawyers a little bit.

In sum, you should judge all the reforms that you hear about by these two standards. What are their effects on injuries and what are their affects on defensiveness?

The conventional type of tort reform fails on these two standards. It does not do anything for all those patients who are injured that are not in the current system. Nor does it do very much about defensiveness. It mainly turns the clock back, makes the legal system a little less intrusive, puts on a few restraints. But it leaves the basic system in place.

Caps on awards, for example, are rather arbitrary. There could be similar but fairer approaches. More measured structures for damages would make more sense. And in any event, as long as doctors are subject to some risk of a process they do not understand and do not like, they may be defensive.

Does the threat of legal process deter, as the lawyers say? My own sense on deterrence, is that it is a very difficult subject to discuss, as Troy Brennan was saying, and the evidence is not good. But I think that although there is probably some useful deterrence, along with non-useful defensiveness, that it is not optimal for reasons described in written testimony.

When I told my 5-year-old son that I was going to talk today about what should we do for people who are injured by mistakes in hospitals, he said "you should give them an antidote." He is an empathetic guy. However, there is no antidote. There is no single magic bullet, otherwise, we would have cured these problems by now. But maybe there are now some valuable vaccines, certainly save with testing out.

Senator ROCKEFELLER. You are telling me that your 5-year-old son used the word antidote?

Mr. BOVBJERG. Five and three-quarters, sir. Christoffer will be six in December. We have been force feeding him from the dictionary. [Laughter.]

I also quickly reassured him after saying there were problems in hospitals. He knows his baby brother is going to be born in about 3 weeks. So I emphasized that these problems are very rare because the people are very careful.

But let me talk about one approach to reform. I would be glad to talk about guidelines also, but that is not my main topic. My topic is the notion that one could list in advance adverse events that occur in medicine, bad outcomes, that really should not often happen if there is good care.

This avoidable approach is closely associated with a doctor/lawyer named Larry Tancredi. He and Clark Havighurst collabo-

rated on the first generation of development. I am Larry's third collaborator in this effort, and we are trying to bring this reform to fruition. It is ready for experimentation.

The basic idea is to look at bad outcomes as a class. The idea is to get away from what doctors and lawyers both do, which is to look case-by-case after the fact and to ask, did Dr. Smith wrongfully hurt Mrs. Jones in this situation? Senator, you and Senator Durenberger referred to the World Series earlier. Now, I am not a big baseball fan; I am more of a basketball fan. But you would never in the world analyze the quality of a batter by getting the experts in to talk about his swing. You would ask a statistician, what is his batting average? That is the basic approach that we are talking about here.

Thinking about classes of outcomes is what epidemiologists are accustomed to, what social scientists are accustomed to, but it is very foreign both to law and to medicine. Nonetheless, these events can be screened based on past information about bad outcomes from malpractice files or from hospital records. And doctors can agree in advance that in general if you have procedure A type with patient class B, outcome C should not normally happen. Seventy times out of a hundred things should be fine if there is good care.

So maybe if such avoidable outcomes do happen, you should treat them differently—in an insurance way, rather than a legalistic way. This system is very flexible: It can be used for liability reform which was the first proposal. It is also a very powerful quality monitoring tool. It is something that hospitals and, hopefully, insurance companies could use to look for these worst examples of bad quality care. It is an outcomes-oriented approach. It is a statistical approach, but it has great potential.

We are trying to move towards experiments. We would like Federal help on that to a certain extent, and we think that in the experiments quality enhancement and defensive medicine should be addressed head on. The reason that these issues are difficult and you see so much dancing around them is that they are financial. So this is the right committee, not the Judiciary Committee, to consider them. We are talking about all these people who are not now in a system, are not now compensated. That is potentially a lot of money, dollars that may move from one pocket to another. We are talking about defensive medicine that can be cut back—again, a lot of dollars that will be moved from their accustomed pockets. Whenever large sums of money move around, a lot of resistance can be expected among the people affected.

A final point, more medical than legal, is that medical malpractice is really the tail end of a spectrum of quality problems. In the long run, health care payers, notably including Medicare and Medicaid which pay for so much, should be moving to more statistical analysis, should be developing data systems to find these problems early, to send better and clearer signals on prevention, and to deal early on with any kind of remedial or rehabilitory efforts that can be made.

Senator ROCKEFELLER. Could you give me some examples of that, clarify a little bit what you mean to me?

Mr. BOVBJERG. The avoidable event notion?

Senator ROCKEFELLER. Yes.

Mr. BOVBJERG. You mean examples of what the events are? I can give you an entire fact sheet.

Senator ROCKEFELLER. No, the preventive aspect that you talked about as you closed.

Mr. BOVBJERG. Promoting preventive means that one should monitor care generally, but especially these worst outcomes. Then one should try to feed back information very quickly to doctors and hospitals where an unusual incidence of avoidable problems occur.

This calls for a system that can make decisions pretty easily and quickly. You cannot have a complicated system, like a bunch of highly paid, very talented Harvard professors coming in and reviewing charts 5 years later. You need something that comes on line rather quickly, identifies problem areas, and facilitates dealing with problems as they arise, many risk managers try to do this now, but they rely on reports from people who are fearful of liability; they have no independent monitoring. Finally, a better system needs to feed back the information in usable, credible form. Doctors do not believe in any information from legal actions about medical quality.

You have crude forms of statistical data feedback now with the so-called death lists that HCFA puts out, the death rates in Medicare hospitals. Death is the one outcome that people can grab hold of and consider an objective measurable outcome. But it is not a very selective measure. We need more intermediate measures of outcomes like avoidable classes of adverse outcomes that we can feed back to hospitals better, so they can ask themselves what guidelines, what new organizational arrangements, what things can we do to perform better?

Dr. Brennan talked about how much difference there was in hospital performance between the low and the high. A major problem is getting that information out there quickly. If you get it out there 7 years later, there is nothing they can do about it. You need to have objective information that comes on line quickly to help people alter their performance.

Senator ROCKEFELLER. Your analogy of the baseball swing, not measuring the quality of the swing, but simply looking at the batting average as a way of measuring how good the baseball performer is. How do you apply that? What is your analogy in terms of medicine?

Mr. BOVBJERG. Consider the predefined avoidable classes of events. You would like to have fewer injuries of these types. Most injuries are unavoidable, just as most batters' swings are unsuccessful. That is one of the lessons of the Harvard study in New York, replicating what was done in California 10 years earlier. But with regard to these avoidable injuries, you measure them, you count them, you develop an avoidable injury index, and you let different hospitals, different obstetrical units, different surgical units, know how they are doing.

The avoidable type of injury may be specific enough that medical practitioners can easily see that they have a problem with a particular type of case or a particular type of procedure and that they should be doing something differently. We do not yet have a final product, a finished system that can be installed everywhere so that with the press of a button all of American medicine will suddenly

be better. Making long-run improvements is going to take a lot of hard work by professionals, largely medical professionals. These are mostly medical issues.

But they can use some help from the insurers and, I think, by some reorganization of liability.

Senator ROCKEFELLER. What you are also implying is that a bad swing in baseball can still result in a good outcome. You can have a very good swing, you can have a very bad swing, you can have a very lucky swing, but if the outcome is measured as a batting average of 300 then you have to say that is good and you pass on.

Mr. BOVBJERG. Precisely.

Senator ROCKEFELLER. That is interesting.

Mr. BOVBJERG. You can spend a lot of time and money investigating each swing. If you do, you are bound to have a system that is slow, expensive, and very unpleasant, especially where a reputation is at stake and the standard is fault.

This is true of any type of hearing, whether in the current judicial system, or in some alternative forum. Any hearing that is retrospective, arguing about long ago events, where reputations are at stake and there is finger pointing—any such hearing is going to be slow, costly, and unpleasant.

[The prepared statement of Mr. Bovbjerg appears in the appendix.]

Senator ROCKEFELLER. Dr. McAfee, as you begin your testimony, would you comment on that? That is fascinating.

Dr. MCAFEE. Sure. I would be happy to.

Senator ROCKEFELLER. Please.

STATEMENT OF ROBERT E. McAFEE, M.D., MAINE MEDICAL ASSOCIATION, PORTLAND, ME; VICE CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. MCAFEE. Thank you, Mr. Chairman. Just as a point of reference I am a practicing——

Senator ROCKEFELLER. Before you do your testimony, could you comment on what Mr. Bovbjerg said?

Dr. MCAFEE. Yes. This is exactly what we are trying to do at the Joint Commission on Accreditation of Health Care Organizations. For years we have conducted a process-oriented paper trail, survey process to give a hospital a certificate.

We have asked, whether this hospital can provide quality care and whether doctors in this hospital can provide quality care. What we are changing to now is an outcome oriented survey process saying, let's use clinical indicators. Let's use these marks of good quality care to then be able to say, having done the survey, that this institution does give quality care.

The difference between can and does, the difference between process and outcome, is critically important in what happens to patients. We are not so much interested in the paper trail, the minutes of the meetings, the relentless discussion of the morbidity and mortality, which should continue, but we are more interested in whether this involved improving indicators of better outcome through the years and not the same outcome, the same rate.

Senator ROCKEFELLER. Please.

Dr. MCAFEE. Well, thank you, sir. I am a practicing surgeon in Portland, Maine. I am one of the past Presidents of the Maine Medical Association and I currently serve as Vice Chairman of the Board of the American Medical Association. On behalf of both of those organizations I am pleased to have the opportunity to testify before the committee today, sir.

In the 1990's we are indeed beyond the point of asking whether there is a crisis in this tort system. We have reached a point when action unfortunately is needed. Many reliable studies have affirmed that without substantial modification or reform the current system is unable to resolve medical liability claims effectively and efficiently. Frankly, the system is not fair to patients.

It is also important to note what the problem is not. Medical negligence is not solely the fault of bad or incompetent doctors. Most adverse medical outcomes are not the result of bad medical care, as you have heard today from the Harvard study.

However, avoidable mistakes are never acceptable. The medical community is committed to continuing efforts to reduce the incidents of injury even further. I would take cognizance of the fact, sir, that the Harvard study did point out that 1 percent of hospital charts show adverse outcomes due to medical malpractice. In inference, 99 percent of what we do is pretty good.

I would point out that there have been previous studies over 10 years ago that gave us a similar figure of roughly 1 percent. Despite the fact that figure has not changed there are many more opportunities for mischief because of more physician/patient interchanges now than there were 10 years ago. So maintaining your 1 percent, actually, I think, shows some relevant improvement.

Senator ROCKEFELLER. Dr. McAfee, I am rude to interrupt but Mr. Bovbjerg was shaking his head when you pointed out that the 1 percent——

Mr. BOVBJERG. That is a slip of the tongue, I think. It is 1 percent of the total. But it is about a quarter to a sixth of those that were injured that are negligent injuries from those two studies.

Dr. MCAFEE. Of those that were injured.

Mr. BOVBJERG. Right. That is correct.

Dr. MCAFEE. What I am saying, of the total cases that were reviewed the incidence was 1 percent of injuries that were caused as the direct result of medical malpractice. Correct?

Mr. BOVBJERG. That is correct. It is not 1 percent of injuries; it is 1 percent of hospital charts.

Dr. MCAFEE. So 99 percent of the evidence was in favor or indicated a satisfactory physician/patient interchange?

Mr. BOVBJERG. Yes, though an additional 3 percent or so had non-negligent medical injuries.

Dr. MCAFEE. Correct.

A unique and innovative local response to the liability crisis is best demonstrated by the Maine Medical Liability Demonstration Project. Based on the need to decrease defensive medical costs and the need to increase access in Maine an unusual coalition was forged to develop constructive responses to a liability problem that had reached the crisis stage.

Legislation in Maine was enacted in 1990 to develop practice parameters and risk management protocols in four specialty areas—

emergency medicine, anesthesia, radiology and obstetrics and gynecology. Under this law physicians electing to participate in the demonstration project will be able to use compliance with the standards, with the parameters, as an affirmative defense in any medical liability suit brought against them for incidents occurring during the 5 years of the demonstration project.

Now by tracking liability claims for 5 years and by comparing data from this period with the previous 5-year period, determinations will be made on the efficacy of using parameters and risk protocols as an affirmative defense. Physicians are being recruited for the program now and on January 1 the right to utilize the affirmative defense will become effective and liability claims will be tracked until the end of 1996.

This project offers an excellent opportunity to determine the use of practice parameters in medical liability litigation.

The AMA strongly believes that patients who have been injured due to negligence should be fairly compensated. Unfortunately, as discussed in my full statement, the current tort system has failed the patient population with too many nonmeritorious claims being filed, too few meritorious claims and transaction costs that dilute legitimate awards.

Studies have shown that the average doctor has a 37 percent chance of being sued for professional liability in his or her life time. This increases to 52 percent for a surgeon and 78 percent for an obstetrician. And, in fact, the 1990 Harvard study concluded that a physician's chance of being sued for medical liability bears little relation to whether he or she has been negligent.

Society as a whole also is harmed by the present system, the spiralling costs generated by our Nation's dysfunctional liability system are borne by everyone. We cannot long sustain escalating liability premiums or the cost of defensive medicine.

I paid my liability premium last month in Maine for vascular and general surgery. The amount of that premium was twice what I paid for my first house. Granted, that was a number of years ago; and, granted, that was a very small Cape Cod house. But it is an annual expenditure that I am forced to make.

Perhaps the most serious societal harm caused by the liability system is reduced aecess to health care. Increasing premiums and the threat of liability have caused physicians to abandon practices and certain services in various areas of the country.

This is not a phenomenon limited to rural areas of West Virginia or Maine for indigent patients. Last month in this very room Senator Riegle, while chairing a hearing on health care system reform, told us that his family is unable to remain with the obstetrician of choice because that physician has given up obstetric practice here in Washington.

Unless the irrationality and the hemorrhaging costs of the current liability system are addressed health care reform will never be achieved. Reforms that work such as those adopted in the States of California and Indiana tell us that the current system is a good candidate for reform and that reform can produce dramatic effects by promoting settlement of valid claims, discouraging frivolous litigation and reducing the time required for claims resolution.

The Federal Legislative Initiatives which have been introduced on the subject of medical liability in 1991 by Senators Hatch, Durenberger, Domenici and Danforth offer many constructive solutions to some of the most perplexing and serious issues in the medical liability arena and we applaud these efforts.

The AMA also believes that a fault-based administrative system, such as the one designed by the AMA specialty society medical liability project, may provide a forum and process for dispute resolution that is fair to both claimants and defendants, more cost effective and more systematic in deterring medical negligence and promoting patient safety than the present system.

We are encouraged by the emphasis upon alternative dispute resolution models and the various Federal proposals advanced to date including that of Senator Durenberger.

The AMA and the Maine Medical Association strongly support current initiatives to promote patient safety and risk management. Any risk management activity must be carefully undertaken so that the physician's responsibility to provide quality care remains paramount.

In conclusion, Mr. Chairman, the problems associated with excessive litigation are not new to the medical profession. The medical liability bill that is being considered today, the recommendations of the President's Council on Competitiveness, the Harvard Medical Practice Study, and virtually every other study that has been completed, all validate what physicians have been saying for 15 years, that the system is broken and it needs to be fixed.

It needs to be fixed to meet the needs of the injured patients who need to be fairly compensated and the physicians who are willing to assume their fair share of the burden from negligent practice and society which needs to reduce transaction costs, eliminate windfall judgments, and assure that physicians can still offer medically necessary services in an atmosphere of fairness to all patients.

The Maine Medical Association and the American Medical Association appreciate the opportunity to appear before this committee, Mr. Chairman, and we would be happy to respond to any questions.

Senator ROCKEFELLER. Thank you, Dr. McAfee.

[The prepared statement of Dr. McAfee appears in the appendix.]

Senator ROCKEFELLER. If universal health access is achieved and everybody in this country has health insurance then health care providers would no longer have uncompensated care and therefore your income would increase. By virtue of that fact, whenever anybody is looking at comprehensive health care reform and universal access as a goal, cost containment, both for physicians and hospitals, is a key component of that. There cannot be the access without the cost containment. I think you understand that.

I also understand when you say that only 1 percent of hospitalizations had adverse outcomes due to negligence. On the other hand, eight times as many people suffered injury from negligence as filed a malpractice claim.

Dr. MCAFEE. That is of that 1 percent.

Senator ROCKEFELLER. That is correct.

But also 14 percent of patients—well, I will do the full statement—57 percent of all adverse outcomes resulted in minimal and transient disability; but 14 percent of the patients died.

All I am trying to say is that in that 1 percent there is a lot of hurt. I do not know how many medical transactions take place in this country but there has to be millions and millions. So 1 percent is a lot, a lot of injury. It has also been pointed out in the Harvard study and by others that there is not much money for State PRO efforts, for doctors disciplining themselves. There is a sense of siege and doctors are naturally understandably defensive about that.

So that when you talk about doctors disciplining themselves doctors are happy to talk about it, but also not so happy to talk about it.

What is it, in fact, if you want to see tort reform and if tort reform comes through, then it certainly has to be fair for Congress to say of physicians that you have got to police yourselves better, discipline yourselves better, that 1 percent is an unacceptable range.

How do you respond to that? What can physicians do to discipline themselves better?

Dr. MCAFEE. I think there are several things.

Senator ROCKEFELLER. I want tort reform. I want to see it happen.

Dr. MCAFEE. I see.

Senator ROCKEFELLER. So it is fair for me to ask you what you are going to do in return.

Dr. MCAFEE. I understand that and I thank you for them. I think there are several things that are happening now and hopefully will happen better in the future. Certainly part of the problem in disciplining physicians is identifying those physicians and carrying through any complaints that are raised.

In that regard I think appropriate funding of the State licensure boards who have that responsibility throughout this country is paramount. Right now much of that is funded through physician licensure. There are other mechanisms of funding that I think need to be looked at just to be sure the costs are not all passed on to a sick patient.

The use of practice parameters is really what we are putting on the table in our major health access reform proposal. I feel personally very strongly about this, having come from Maine where for 11 years now we have been involved in the geographic variation studies that created the Maine Medical Assessment Foundation.

We have found that looking at variations that occur not because of bad actors, not because of outlers of medical care, but because of practice styles that were very appropriate perhaps at some point in the past, that some may have been educated in the best institutions in our country, but may for whatever reason have not been made aware of newer developments, alternative therapies to expensive surgery to achieve that outcome over here that we are beginning to measure.

And when we see by having a 100 percent data base in our State for every hospital discharge and see a rate for a surgical procedure or a rate for an inpatient pediatric medical service being very high in one part of the State compared to another with similar sized

cities then we ask ourselves, why is that. Is that because of an epidemic of disease or is that because of practice style of physicians?

Being in a small State the influence of a very few physicians can reflect itself in that small number. As a consequence, within the profession, one can then sit down with true peers around a table with the doors closed with nobody there from a licensure board, a payment from a State government, a credentials committee and say, Charlie, "Why are you doing this operation three times more than Joe here 30 miles away?"

And you develop a surgical signature of what he does, let's say for a hysterectomy, and of the 12 common reasons for doing it, there is no disagreement with 11. But on that twelfth, pelvic pain, which doctors around the table otherwise are treating with medication, Charlie is treating with surgery.

As a consequence of that you say to him, here is a suggestion. Let's come back and look at your practice behavior 6 months from now. We can do that because of the data we have that is current—99.9 percent of the time, Mr. Chairman, I will tell you that physician behavior has changed for the better in that interchange, simply because the motivating factor for physicians, which many people forget is the fear of mutual lack of trust and respect for each other.

I will tell you within the profession that remains a highly useful motivating factor because most physicians want to do what is right. Utilizing that mechanism reduces our outliers significantly. We can then create more and more parameters.

This dovetails very nicely with our risk management program. I would be adverse if I did not point out, and I am not in defense, I would be the last one to try and defend our insurance system in this country, but 60 to 70 percent of medical liability in this country is now written by physician captive companies which are nonprofit companies whose stockholders are the subscribers.

There are no dividends. There is no profit to be generated. Any dollars that are saved are plowed back into the corporation to reduce or contain premiums for the following year.

Senator ROCKEFELLER. How would that interrupt what Dr. Rydland said about a 900 percent increase in the last 6 years? She obviously is not in the 60 to 70 percent?

Dr. MCAFEE. No, you are in that. But the experience rating over those periods of time, the amount of monies being paid out for whatever reason by that company has exceeded premiums by that factor of 300 to 400 percent.

Those numbers which indicate that those are not dollars going to patients, they are dollars going to the system. Therein lies the problem. The system is gobbling up more than we can afford.

Another basic concept that I try to be sure that my interns and residents are aware of in my hospital, I do not have malpractice insurance. I do not buy insurance that allows me to create malpractice. I have insurance that is called professional liability insurance based on a time-honored traditional concept that once the patient is under my care, during my surgery, pre-and post-operatively, I have an ethical, professional responsibility to care and cover any instance that happens to that patient by this system not being perfect.

And up to about 10 years ago this insurance was affordable. It was affordable as much as my heat and lights and electricity were affordable that I passed on to patients as part of my fees. The last 10 years the escalating costs have not been affordable to me or my patients. That is why this outpouring of concern by the profession saying we just cannot continue to pass this off onto patients.

The $700 per month of the day of the OB that is unconscionable for the young parents about to have their first child. What we are saying is that we can only contribute so much financially to this system to the point where it gets that no one can afford it. And if the system becomes increasingly unfair to patients, and that is why the alternative systems are there—that may be more expensive for doctors. It certainly will initially because you are going to invite many of the patients whom we have identified that have an adverse outcome to more easily be involved in a system that would seek retribution for them. And we are ready to accept that.

But if at the same time we can condense the time frame involved, if we can limit the amount of excessive payments for pain and suffering, not the economic rewards that somebody deserves, if they have been injured and need to be covered over time, but the noneconomic numbers—the million dollars for the psychic because they have lost their ability to do whatever they do—has got to be part of that reform system.

We are willing to turn that over to an administrative law judge at a State system, after appropriate screening has been developed. But it must be an alternative, not an add on, not something that you do before you go to court. Because the legal costs on both sides of that aisle is what is chewing up those dollars that are not getting back to patients. That is why we feel strongly about the issue.

Senator ROCKEFELLER. That is very extremely well said, Dr. McAfee.

Mr. Bovbjerg, let me ask you a final question. This matter of instinct to sue I was taken to task on that. It is interesting about America. It was pointed out that we have the most protective private rights in our Constitution, the Bill of Rights, that is what we are all about.

What is your judgment about the fact, on the one hand, that a lot of people who could be suing and perhaps have claim on malpractice are not suing as Ms. Gilbert pointed out; and on the other hand there is this sense on the part of doctors and some of the rest of us that the whole thing is kind of spinning out of control. That is, people lose their own sense of control about what happens in their lives, that they tend simply to point at others.

But how do you describe the balance as you see it in our country?

Mr. BOVBJERG. I would say that our country is one of the most, if not the most litigious for some of the reasons that I believe one of your colleagues was listing. However, in general people do not like to sue because it is costly, unpleasant, and slow.

Americans are quicker to call lawyers, as the witness from Public Citizen said. They are very quick in the case of auto accidents or workers' compensation. In contrast, they are very slow in other areas, although I am not sure that she cited one of the studies correctly on that point.

There is very sketchy information about why people make claims in malpractice or anywhere else. It does appear that patients who have problems are less likely to seek out a lawyer than, say, an auto victim that has problems. Auto victims recognize that there is a problem. They do not have any compunction about suing another driver. They are used to that. In fact, my suspicion is that physicians are more often defendants in auto cases than in malpractice cases, even after the rise in malpractice claims in the last 20 years.

So it is a matter of change in level. We have more malpractice suits now than Dr. Welby faced, but we still have many, many fewer suits than there are actionable bad outcomes. I am not here to offer any argument that we need more of today's kind of system because of the unbrought suits. But I do not think it is acceptable to say, that we need less of the same, as medicine used to argue exclusively.

Many of the conventional tort reforms are precisely that. They are less of the same system, which leaves even fewer people covered, for even less damage. Many conventional tort reforms have a very arbitrary nature. Take a cap on awards. One cap cannot fit all heads. Circumstances are different. It would make much more sense to require a structured approach to damages, a whole series of guidelines for awards.

You are familiar, of course, with the concept of fiscal neutrality. You could achieve the same outcome in terms of fiscal flow through the liability system with a structured series of caps and floors that you achieve with one arbitrary cap that applies only to the most seriously injured.

But I think that there are very positive things happening. I will repeat that the most important thing from this committee's perspective is not to worry too much about how the dispute system performs. We do need a dispute resolution system, but the most important issue for health policy is how the medical system performs in attacking the problem of medical injury.

I think we will always have more disputes here than some countries have. But I do not notice a lot of people moving to those other countries.

Senator ROCKEFELLER. That is well said also. Maybe we should stop at this point. My own conclusion is that this is massively difficult and for that reason it is going to be very difficult to do anything, even incremental about it. But those of us who believe that the health care system is in crisis and that part of the reason for that is the overwhelming cost of defensive medicine.

It certainly is not the whole solution. But I think it is really unfair to say it is not part of the solution and that we have to go at it if we can do so in a way which protects victims and yet also does not create a situation where physicians are simply declining to be physicians.

I have a cousin, Dr. McAfee, in your hometown who you know, who practices medicine. He is a family physician, and he tells me that many of his friends in their late thirties and forties are simply deciding to get out of medicine altogether. They cannot take it anymore.

Whether that is a perception or whether it is not, whether they perceive ill where there isn't or whether they perceive it correctly

is not the problem, they are getting out. That cannot happen. We have to address it and we will.

This hearing has been long and I apologize to you for that. I do not really because we are talking about something awfully important.

Thank you all very, very much.

Mr. BOVBJERG. Thank you.

Dr. MCAFEE. Thank you.

[Whereupon the hearing adjourned at 1:20 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF RANDALL R. BOVBJERG

The most important goal for malpractice policy is to prevent malpractice. More specifically, policy makers should strive to minimize the costs of avoidable medical injury plus the costs of injury avoidance. There are good reasons to believe that the current oversight imposed by liability law and insurance are not optimal, although these systems work better than is commonly asserted. That is why we are all here this morning. Just what reforms would work better is open to question, as is just what it means to "work better." Throughout this testimony, the perspective is that reforms should mainly be crafted to help patients, not the class of plaintiffs or of defendants, nor their attorneys or insurers. And for patients, maintaining and enhancing the quality of medical care is the pre-eminent concern.

This testimony begins by assessing the most salient malpractice problems—in medicine, law, and insurance. It then discusses the spectrum of potential legislative solutions, "tort reform" and others, considering their likely effects on problems in light of existing evidence. It concludes by recommending intensive and far-reaching experimentation with a number of reforms, most notably the "avoidable event" approach to quality and malpractice reform.

I. THE NEED FOR REFORM: PROBLEMS IN MEDICINE, LAW, AND INSURANCE

The system of medical liability really comprises the three interrelated systems of medicine, law, and insurance. Analysis of potential solutions must begin with consideration of the maladies in need of remedy in each system.

A. Medicine

The largest single relevant medical issue is the extent of medical injury. Here there is good news and bad news. The good news is that the absolute rate of negligent medical injury is quite low. About one percent of hospital medical records contain evidence of negligent injury. This is the main finding of two thorough reviews done ten years apart in two different states, California in 1974 and New York in 1984. Dr. Troyen A. Brennan is testifying about the New York Study from his personal participation. There appears to be no systematic information on injuries in other sites, and in general, the "epidemiology" of medical injury is very poorly understood.

Whether one percent is good or bad depends on one's expectations. To me, one percent seems very good, given the length and complexity of much hospital care and the multiplicity of personnel typically involved. But what really matters is whether the rate can be made still lower with reasonable levels of effort.

The bad news is that one percent of tens of millions of hospitalizations annually is still a very large number. As a colleague at the Physician Payment Review Commission often notes, if negligent injury were a disease, it would get a lot of NIH attention. Moreover, it appears that the elderly are especially likely to suffer negligent injury—a special concern for Medicare. Incidentally, both the large studies estimated that the number of negligent injuries in hospitals exceed the corresponding number of claims by a factor of eight or ten. This commonly cited statistic leads some observers, especially attorneys, to assert that we need more liability cases, along with better medical discipline. This conclusion does not necessarily follow, as explained below.

As noted, not enough is known about how negligent injuries occur and why or about the best ways of preventing them. Some assert that a few "bad apples" are

mainly responsible, people who might be identified through a malpractice payments data bank and enhanced peer review or disciplinary authority. Insurance data are the main way used to assess this theory. It is true that in any one year only a few doctors and hospitals account for most payment dollars, but this is necessarily so. Malpractice claims are rare, and payments rarer still (about 50% receive payment), while payment levels are relatively high, so that the distribution of dollars is inherently skewed. It is also true that the class of physicians with a history of high claims also has substantially higher subsequent claims. But this concentration of claims by no means explains all claims.

In sum, medical injury is thankfully rare but unfortunately much more prevalent than attempts by any system to remedy it. The extent of avoidable negligent injury is probably the biggest single problem in this whole area of policy concern. The magnitude of avoidable injury is also the major roadblock to thorough reform: Most reformers are unwilling to address the large share of valid cases that go "undiscovered," lest the full cost of avoidable injuries (now borne by other payors and by patients) become too visible . . . or even be increased by imposition of different remedial processes.

B. Law

Law purports to be the main social system for those suffering medical injury. Legal theory suggests that imposing liability serves two main social functions—compensation and deterrence. Law also exists to provide justice—a socially acceptable way to resolve disputes in individual cases. By deciding liability fairly in individual cases, based on negligence and causation of injury, and by then imposing precisely those damages caused by the negligence, the law expects not only to compensate individual deserving plaintiffs, but also to motivate all potential defendants to act with due care for all their patients. There are many reasons to assert that liability practice does not achieve this ideal. Because legal rules on liability are so vague and because each case is decided separately, if necessary by a lay jury, results are necessarily unpredictable. Anecdotes abound about the seeming unfairness of liability and damage determinations.

More systematic evidence paints a much less bleak picture about the whole universe of cases actually resolved. In truth, the liability system is not irrational, despite what some defendants believe. In the aggregate, though not in every case, it does much better than defendants assert in fitting liability to medical evidence, and damages to losses, in the cases that are brought. This point needs emphasis here, but space does not permit full support.

1. Compensation

The biggest failing of the liability system is that *so few* cases are covered. In fact, the law in no way constitutes a compensation system, despite the many discussions of compensation in legal treatises. The reason is that it has no systematic way of finding appropriate cases to compensate. It merely relies on cases brought to court. Just how injured parties and their attorneys decide on claims and suits is also poorly understood. It does appear that a far lower percentage of injured patients seeks legal counsel than do injured motorists, the largest category of liability litigant. And it seems clear that lawyers consulted turn away the majority of potential claimants for lack of a winnable suit or for insufficient damages to meet the high costs of proving negligence, causation, and damages. Because so few cases are brought and paid, the main compensation systems for negligent medical injury are health, disability, and life insurance plans—the same plans designed to compensate injuries more generally. Do not be fooled by the legal terminology that belittles Medicare and other payors as mere "collateral" sources; in practice, these plans are the main payors, and liability a minor player. In short, most costs of malpractice and other avoidable injury are hidden within non-malpractice insurance.

There is little doubt that the system is slow, costly, and unpleasant—on all sides—which probably also deters claims. But some of these shortcomings would be true of any system that decides such complex issues using expert witnesses on a case-by-case basis after the fact, providing great procedural protections to all parties. Still, delay and high transaction costs also hurt the system's performance for compensating injured patients. If the system were only a compensation system, society would probably have scrapped it years ago as woefully inadequate.

2. Deterrence

But liability is also meant to deter substandard care, thereby raising the quality of care and preventing injury. This is its highest and best role. How well does it do? On the positive side, it is logical that people facing liability should be more cautious, and anecdotes abound about safety measures taken under the liability climate. Fear

of liability has seemed central in promoting improved guidelines for care in anesthesiology, for instance, and far greater attention to risk management. There is also very tentative evidence from the New York hospitals with higher claims rates may have lower rates of injury.

On the negative side, again, the failure even to identify most negligent injury is a major minus. It is possible to promote quality without investigating the entire universe of cases. For instance, manufacturers traditionally relied on "spot checks" or random samples for quality testing. (Today, "zero defects" and "continuous quality improvement" for all cases is becoming more common, but that is another story.) And highway patrol officers stop only occasional speeders. But these "spotty" enforcement tools are at least enforcing a clear standard (functioning widget or 55 mph), and their enforcement relies on random sampling or targeting the worst areas for complete monitoring. Civil liability does not work like that. Unfortunately, systematic evidence on how well deterrence works is unavailable, although efforts are under way.

My own working conclusion is that deterrence exists but is not as large as it should be. A final dispositive factor in my own mind is the observation that doctors and other medical decision makers perceive liability as arbitrary and irrational, so cannot appropriately process the deterrent signals that exist.

In sum, legal process works better than commonly believed. How severe problems are depends on how one sees the law—as a mechanism meant only to resolve individual disputes brought to it or instead as a compensation-deterrence system meant to address the universe of negligent medical injuries. Under either perspective, there are reasons for concern. Again, further improvements in rules and process most definitely remain desirable.

C. Liability insurance

Liability insurance is central to malpractice issues, but poses no key policy problems under today's system. Liability coverage is what makes legal rulings so consequential. Without insurance to finance awards, far fewer cases would be brought and far less attention would be paid. And without insurance personnel to process claims, the judicial system would be unable to cope with all the claims made. Further, malpractice has largely arisen as a policy concern because of "crises" in liability insurance.

Nonetheless, there is not too much "broke" with liability coverage that calls for fixing. This conclusion is quite robust, despite a number of potential complaints about liability insurance. It is true that, because of underlying cycles in made and in insurance markets, are periodic "crises" arise. Physicians' legislators are very familiar with this phenomenon. You should probably brace yourself for the next round, as malpractice claims frequency seems now to be on the upswing again nationwide. But the causes of these fluctuations in the extent of claims as well as the price and availability of coverage are poorly understood, and it is not clear any particular policy problem would effect changes desired by some. Not too long ago, it was not implausible for advocates to blame insurers for creating crisis and for overcharging. This is no longer so. Medical providers now provide most of their own coverage through mutual companies, self-insurance, risk retention pools, and other such mechanisms. Empirical analysis confirms what is intuitively obvious—that insurers are not overcharging physicians.

In sum, no major policy problems seems to exist. To be sure, cycles remain troublesome; individual insurers and risk retention groups can have fiscal problems and even fail; and insureds can feel ill-treated by their insurers, especially where in high-stakes litigation their interests are not congruent. But these problems are not unique to medical liability coverage, there are corrective mechanisms in place, and no obviously helpful policy levers commend themselves.

D. The Overriding Reason for Concern—Defensive Medical Practice

Problems of medical and legal quality are not unimportant, especially the failure to help most deserving patients. But the "big ticket" that attracts policy attention is "defensive medicine." It is widely believed that positive defensiveness adds significantly to the nation's medical bill, notably including those for Medicare, Medicaid, federal employees' coverage and others of direct concern to the Senate Finance Committee. These are the extra tests and other measures physicians and others say they perform mainly for potential legal benefit rather than medical benefit. Of course, it is again health care payors who bear the costs of such positive defensiveness, and who may meet resistance to case management and other initiatives based on fear of liability.

There are many numerical estimates of defensiveness available, but all are imprecise, and this testimony is not going to lend support to any one of them. Although

defensiveness clearly exists, in medicine as in most other phases of American life, putting a dollar value on its precise extent is almost a hopeless task. For one thing, there is no consensus on just what is medically useless, and many defensive measures in fact have some utility (like better record keeping and spending more time with patients). Moreover, there are other reasons for defensiveness, for instance, placating demanding patients and avoiding regret that not "everything possible" was done for a patient under a health financing system that imposes few extrinsic constraints. Negative defensive medicine is even harder to quantify and ultimately more troubling, that is, withdrawal from provision of certain services, to certain patients, in certain areas. Negative defensiveness may not cost money (in fact, it may save money, as two of my colleagues have suggested), but it does reduce the value of medical care.

In sum, defensive medicine is a very large issue in need of special attention, second in importance only to the magnitude of avoidable medical injuries. Yet few past or proposed reforms directly tackle defensive medicine, as discussed further below. Curbing defensiveness is probably going to require direct approaches, involving both new education and changed incentives. It is insufficient to rely on the indirect effects of any liability reform to cure defensiveness.

II. PAST AND PROPOSED SOLUTIONS

A. Insurance and Medicine

In the interests of space, this testimony can offer only the briefest discussion of medical and insurance reform, past and present. Legislatures have enacted a number of insurance reforms, most notably with regard to Joint Underwriting Associations at the state level and Risk Retention or Purchasing Groups by Congress. The key factor in alleviating availability problems, however, seems to have been the "self help" of health care providers in funding their own insurance entities, in part through retention groups, but mainly through more conventional insurance entities.

Quality enactments have also been common, seeking enhanced disciplinary information or funding, and attempting to shield legitimate peer review from unwarranted legal action. No one seems to believe that these actions have had a major impact, but I am unaware of any thorough assessment. Forms of "risk management" have been shown to affect care and claims. The most promising potential reform is the "guidelines" movement, prompted in part by liability concerns, in part by the surge in quality/medical outcomes research, and in part by payors' search for ways to constrain traditionally open-ended payment. At their best, guidelines constitute a laudable attempt to make medical decisions more scientifically, with the best available evidence on efficacy and safety.

Processing medical information better and making standards more scientific are highly desirable goals. Where successful, guidelines should improve medical outcomes and reduce medical injury. As a byproduct, they may help good care defend itself in liability actions and reduce the expense of claims handling, although there are technical legal issues about their introduction in courtroom evidence. Guidelines may also make it easier for lay patients and lawyers to identify low quality care, with repercussions for doctors' business as well as their liability posture. If believed, they may also make possible, although not necessary, a reduction in inappropriate defensiveness. There are dangers, however, that guidelines may be misused or even that they will be designed with legal defense in mind rather than the best interests of science and of patients. All of this is rather speculative at this point, although the guidelines in anesthesia seem to be very successful in helping patients and practitioners alike.

B. Legal Reforms

The spectrum of solutions here contains three main categories: (1) The first option is to work *within the system,* that is, to leave the current rules and processes of tort law and liability insurance in place, but with reforms. (2) The second type of reform maintains the same basic, fault-based, case-by-case approach to determining malpractice, but *changes the forum or processes* of decision making. (3) Third come more fundamental reforms, calling for a wholesale change in the entire approach to medical injury.

1. The Current System, with Reforms

(a) The main option here is **conventional tort reform.** "Conventional" tort reform means legislating any of a great variety of limitations on judicial practice. Such reform seeks to limit many of the now traditional legal prerogatives of plaintiffs in personal injury cases, in a sense to "turn back the clock" of pro-plaintiff judicial developments through legislation. Reform leaves in place the current liability

system of courtroom justice and payment through liability insurance, with changes in the rules and procedures. The standard approach began in response to the "malpractice crisis" of the 1970s, spreading further during the more widespread "liability crisis" of the 1980s. Every jurisdiction has now enacted some element of conventional reform, which medical and other potential defendants continue to promote. Nonconventional reforms largely remain on the drawing board.

Most tort reforms either seek to limit the number of suits, reduce the size of any payments made, or increase the difficulty of winning. Some attempt to improve judicial administration or reduce the costs of judicial process. Politically, caps are the centerpiece of conventional state tort reform, now elevated to Presidential status. Legally, they are the prototypical limitation on plaintiffs in favor of defendants. Empirically, they achieve the biggest impact on plaintiffs' claims and defendants' premiums—the most buck for the bang, one might say. Hence they deserve the most discussion.

Most caps limit only the "noneconomic" elements of loss, most commonly to about $250,000, as in California, but the ceilings range widely. Noneconomic losses are those with no obvious pecuniary valuation, such as "pain and suffering" or "loss of enjoyment of life." Most states set no cap for economic losses like medical bills or lost earnings. Rarely, as in Indiana, all losses are capped, tangible and intangible alike. Caps are a political success. First, they are popular, now enacted in almost half the states. Second, caps in general clearly work as intended. That is, they have saved money for defendant medical providers (and their insurers) at the expense of those with large malpractice claims (and their lawyers). A lot of money. Paid claims in cap states have been found to average almost 40 percent lower than elsewhere, other factors equal. They have also been found to reduce by about a third the liability premiums that physicians must pay. Since the inconclusive early years of reform, empirical findings of caps' effects seem to have been consistent in direction if not in precise magnitude, regardless of whether the study lumped all caps together or distinguished among types of caps. In addition to regression analyses using large data bases, evidence on this score comes from the systematically compiled opinion of experienced claims adjusters, as well as the judgment of informed individuals, especially from the defense side. Practical confirmation of caps' importance comes also from the vehemence with which caps are supported by defense interests and opposed by the plaintiffs' bar.

A few other restrictions are also successful in this same limited sense of helping defendants. Notably, "collateral source offset" and reduced "statutes of limitations" of various kinds are thoroughly demonstrated to curb claims. Along with caps, these are the "big three" of conventional tort reform. Other limitations and changes in rules or procedures have not been shown to help defendants, at least not consistently so in published analysis. It may be, however, that enacting a combination of reforms has a collective impact on liability settlements and judicial awards that has not been disentangled by statistical analysis. Certainly, practical advocates of the defense position are convinced of the desirability of periodic rather than lump-sum payment for future losses, requirements for certification of meritorious suit, and other such limitations. Two final notes on findings: Empirical analysis has not clarified just how caps and other limits achieve their dollar cuts and with what other effects in law, medicine, and insurance. Also, trends in claims seem to follow some separate dynamic of their own, as claims filings have twice waxed and waned nationally over the past twenty years, seemingly without direct relation to specific legal developments in individual states.

Conventional caps on malpractice awards are a "halfway technology." Caps legitimately treat one symptom of the general legal problem of damage valuation—the open-ended nature of liability. But they do not address the entire syndrome of vague rules of damages, little guidance to decision makers, and unnecessarily inconsistent valuations. They merely prescribe crude amputation for the cases of most severe injury.

(b) **Further reforms on damages** are in order. Caps are a legitimate response to the chilling effect of open-ended legal liability. It is not reasonable that every jury should have virtually unfettered discretion in deciding the value of injuries. Especially not for nonpecuniary losses like pain and suffering or loss of enjoyment of life, where quantitative legal guidance is currently nonexistent. Where the sky is the limit, some awards inevitably soar too high. And consistency across cases is impossible to guarantee under an unreformed system. But one arbitrarily sized cap cannot possibly fit all heads. It is not reasonable that every injury should have the same maximum award, whether minor or major, temporary or permanent, lifelong for a child or lifelong for an octogenarian.

Instead of fitting one cap to all cases in Procrustean fashion, better reform would create new structures to guide damages at all levels. It is not logical that juries need mandatory quantitative guidance at the cap level and none whatsoever below that. In place of one nonpecuniary cap, a set of values could readily be created, based mainly on severity and duration of injury, that would prescribe, or guide, allowable damages for all levels of injury. True, the top level of such an improved system would create one ceiling, but only as part of an entire structure, with floors and ceilings and compartments appropriate to different areas.

Various approaches to such structuring exist, both within the current legal framework and under an alternative administrative or insurance approach, such as that proposed by the AMA and Medical Specialty Societies. Indeed, the AMA plan would feature caps graduated by severity—though not floors. Similarly, methods of calculating economic damages also merit measured reform in place of arbitrary capping. In general, the goals should be to improve the accuracy, predictability, and consistency of awards and to reduce the time and cost of adjudicating cases. Damage rules should be clarified, and juries or other decision makers should be informed of typical awards or settlements in other, similar cases—just as judges are told what other judges have ruled on matters of substantive law. Moving toward such quantitative "precedent" has been suggested, but apparently never tried. Other changes with regard to structuring awards are also worthy of consideration, especially for the future losses that loom so large in high awards. Most of these ideas apply beyond malpractice and should be considered for liability law in general.

No conventional tort reform (passed or proposed) seems to do much to ameliorate defensive medicine. Anything that improves the medical perception of the legal process arguably is helpful in this regard, but my suspicion is that most conventional reform cannot do nearly enough to make much difference. There seems even less evidence on reduced defensiveness than on the extent of defensiveness to begin with, however. My mental model is that physicians, like other people, do not want to run any risk of a lawsuit if they can avoid it, especially not one that may lead to damages exceeding the limits of their liability coverage. Turning the clock back somewhat seems unlikely to lower risk enough. After all, there were bitter complaints about defensiveness twenty years ago, and no conceivable reform could lower the likelihood of claim to those levels.

(c) **Alternative Dispute Resolution,** or ADR, is another way of working within the current system, at least where done voluntarily. ADR encompasses a whole complex of ways to facilitate settlement of claims outside traditional courtroom process and unassisted negotiation between courtroom advocates. Ideas range from the familiar arbitration and mediation to private jury trials and structured negotiations through an intermediary. ADR has received much attention of late, but evidently little thorough evaluation. Arbitration is one reform sought to be evaluated, but so few current cases are arbitrated that assessment is difficult, as the GAO recently found in Michigan. In a sense, the lack of evaluation is unimportant, for people will only use a voluntary method if it helps both sides. ADR potentially also holds lessons for conventional judicial process and might even inject some "healthy competition" for the courts. Voluntary ADR should be vigorously promoted and evaluated.

In sum, staying within the current system means accepting the view that liability mainly exists to resolve disputes now brought to the courts, using traditional standards of fault, causation, and damages to resolve individual cases, though possibly with new, ADR processes. Such reforms typically do little or nothing to find more "undiscovered" cases, to promote prevention of injury, or to address defensive medicine. They are, however, commonly promoted in conjunction with a similar case-by-case regulatory reform, namely "beefed up" state discipline of physicians.

2. Similar approach, but in new forum or with new process

Next come non-conventional reforms, ones that go outside the bounds of familiar judicial-insurance process and forums. In general, however, they also seek to resolve only cases brought forward by claimants, using conventional rules of causation and fault, through case-by-case decision making.

(a) **Mandatory ADR** is one such reform—compelling binding arbitration or other some other option from an approved menu of choices. Where ADR is sought to be imposed on a mandatory basis, there is much more reason for concern about its proposed process and likely effects: The loss of voluntary adoption means that all parties may well not agree that ADR is preferable. There are also questions whether ADR mechanisms exist or can quickly arise to begin handling the volume of cases now handled conventionally throughout the country.

(b) **The AMA/Medical Specialty Society** proposal for fault-based administrative resolution of malpractice claims is another such proposal. It is carefully crafted, at

least attempts to bring more small claims into the system, tries to routinize many determinations to build consistency and save transaction costs, attempts to assure that decision makers would become expert, and has ties to a particular form of quality reform through discipline. The plan does not truly reach out to injured patients and builds in no on-going tie to quality feedback within medical institutions. It can also be attacked as too pro-defendant. With some modifications, however, it is worth a careful test in a willing state; my understanding is that one or more may be interested.

(c) The **Physician Insurers Association of America (PIAA)** plan is another thoroughgoing change. It would regularize calculations of damages, but makes fewer suggestions with regard to other process. It appears most suited as an adjunct to other reforms, but might be mandated as a change in damage rules under the current system. In sum, these larger changes to the conventional liability approach have some merit. However, None of these reforms does much, if anything, however, for the legitimate cases not now brought. Some might be redesigned and tried on a trial basis.

3. More fundamental reforms

These reforms come in a number of varieties, many (misleadingly) categorized as "no fault." No serious proposal would cover all bad outcomes arising out of medical care, because most are due to the underlying illness or condition for which care is sought. This is very different from auto no-fault, which truly covers all injuries arising out of auto use, or from Workers' Compensation, which covers all workplace injuries. Broader reforms seek to go beyond disputes now brought to the liability system. Consider the following proposals:

(a) The broadest possible approach would be similar to that used in **New Zealand**, where all injuries are covered through social insurance—including medical ones. To my knowledge, no one proposes such an expansion of social insurance here. It is said that even New Zealand may be backing away from this approach.

(b) There has been some support for a **"Workers' Compensation"** style of medical injury compensation, at least where limited to serious injuries and where paying very restricted amounts of damages. Many of the Harvard team of researchers who conducted the New York hospital study favor such an approach.

(c) Even more restrictively, selective no-fault statutes like the Virginia and Florida statutes on **severe, birth-related neurological injury** aim to allow some recovery on a semi-automatic basis to a very few injured claimants.

(d) Another alternative, in a different vein, is **voluntary contractual agreements** allowing providers and patients (or groups of patients) to establish their own private liability remedies, in lieu of the current "monopoly," public legal regime. These contracts could include any of the other reforms noted here and many more. There are significant advantages, in theory, to letting people decide for themselves what style of medical care they want, including what system for dealing with medical injuries. The concept remains somewhat academic; its closest practical analogue is the use by some HMOs of binding arbitration. Broader contracts remain controversial and would probably face significant judicial challenges.

In sum, all of these fundamental reforms, to greater or lesser degree, emphasize the compensatory function of liability insurance rather more than the deterrent one. States or other entities may still wish to experiment with them. However, the reforms do not specifically address deterrence. The final reform for discussion here is a promising approach that ties together medical and legal concerns, addressing both deterrence and compensation.

C. The argument for focussing on avoidable injuries

The basic idea of this family of reform options is to create better incentives to prevent *avoidable injuries* in medical care. This reform operates by creating pre-defined lists of bad medical outcomes that should not normally happen when patients receive good care. The lists do not cover all injuries, just classes of adverse outcomes that are professionally agreed in advance to be generally avoidable. The standard is avoidability, not fault. The view of causation taken is a statistical one, as in epidemiology, not a clinical or legal view of specific causation in a particular instance.

These avoidable outcomes are dubbed "accelerated-compensation events" when used for a payment system. But "ACE" could just as readily stand for "avoidable classes of events," and ACEs have uses beyond liability reform, notably to promote quality of care. Medical experts create ACEs by reviewing information on injuries, then generalizing to sets of events that qualify for designation as ACEs. The three main criteria for being listed are that: (a) the events are readily specified and distinct from similar non-ACEs, (b) they are moderately or highly preventable as a

class, and, (c) listing them does not distort medical decision making. Examples include falls from an operating table, instruments unintentionally left inside patients during surgery, and postoperative displacement of any surgically implanted internal orthopedic device.

ACE lists can be used to improve today's legal and quality-monitoring systems or to replace most of malpractice law. ACE-based tort reform avoids traditional legal approaches. In contrast, the conventionally reformed tort system continues to rely on legal rules, processes, and personnel. Whereas ACEs seek to acknowledge medical *responsibility* for a class of adverse outcomes, the law seeks to establish liability for particular past transgressions. ACEs thus look *forward.* They are promulgated prospectively, encourage early rehabilitation, and promote prevention of future injuries. The law instead looks *backwards.* It seeks to prove liability retrospectively, emphasizing restitution and, often, retribution. Other differences in approach:

ACE System	Tort Reform
• is based on ***avoidability*** of injury	• seeks to prove ***fault***
• targets avoidable ***outcomes*** of care	• considers ***process*** of care in each case
• sets ACEs ***dispassionately*** in advance	• judges fault in ***emotion-laden*** context
• makes ACEs ***uniform*** for all cases	• sets standards ***separately*** for each case
• derives ACEs from ***medical science***	• ultimately relies on ***lay juries***
• applies soon ***after injury***	• operates ***after the fact,*** often long after
• ***generalizes*** outcome classes from statistics	• uses highly ***individualized*** standards
• fosters ***predictability*** by standardization	• yields very ***unpredictable*** results
• uses non-liability ***insurance style*** process	• applies ***courtroom*** process to disputes

ACEs are a promising new approach in quality reform as well, mainly because ACEs concentrate attention on medical outcomes, the key focus for good quality monitoring and intervention. ACEs also ties the adverse outcomes specifically particular medical treatments and types of patients (notably, often distinguishing high-risk cases). This feature avoids the problem that other outcome measures face of having to adjust statistics for patients' severity of illness or facilities' "case mix." ACEs also provide a framework for assessing and encouraging quality in medical practice. These systematic listings make professionals think in terms of statistically avoidable outcomes—and on a continuing, practical basis, not only for one-time, research purposes.

ACE lists can be used to monitor the incidence and prevalence of adverse outcomes in institutions and in private clinical practice. The results could be a basis for comparison across providers and over time. Learning of these results should promote self-improvement. By definition, ACEs are scientifically validated classes of avoidable injuries. Hence, "feeding back" information on ACE performance to practitioners should stimulate constructive responses—quite unlike the defensive response to findings or fears of legal liability.

A maturing literature explains the scientific methodology of ACE development and the benefits of ACE-based reforms. Research shows that ACEs are feasible to develop and apply in practice. ACE-based payment reform would help both patients and physicians, improving both compensation and prevention of medical injuries. Quality reform would also be helpful, regardless of liability reform. This family of reform options offers one of the few promising, fundamental reform ideas in quality and malpractice.

In sum, such ideas deserve a field test. Dr. Laurence R. Tancredi, an originator of the concept, and I are seeking to test versions of this for liability reform and for quality reform only, both mainly in obstetrics, a special problem area of great social concern. The liability reform is tied together with a direct attack on defensive medicine and meant to be achieve savings for Medicaid and other payors. The quality reform is seeking links with other "outcomes" based approaches to monitoring and assessment.

III. RECOMMENDED FEDERAL ACTION

The federal government can help. In the near term, it can encourage experimentation by states and other entities, both for medical and legal quality. Today is a good time for experiments, for we are now in a lull between "crises," though insurance problems may soon return. In the long term, the federal government can help Medicare and Medicaid more actively seek prevention and early detection of avoidable injury, encouraging others as well.

In sum, federal action is warranted, both now and in the future. Not enough is yet known, however, to impose a single, mandatory federal "solution." We should know more soon, after some new ideas are tried.

IV. CONCLUSION

Today's unduly erratic and expensive liability system for medical malpractice undercuts its own goal of compensating victims. Its lack of scientific legitimacy hampers its other main goal of deterring injury. The liability system works better than many detractors acknowledge, so it should not simply be arbitrarily cut back. In the short run, it should be improved. In the long run, it should probably be replaced, but only if the replacement better protects patient interests. The two key patient interests are avoiding medical injury and ameliorating medical defensiveness.

Although reform is definitely in order, most "tort reform" fails to make fundamental changes and does not help the vast majority of patients with avoidable injuries or promote quality of care for all. Alternative systems, especially those bases on organized lists of classes of avoidable medical injuries, or "ACEs," offer a better way to replace or improve judicial resolution of liability claims. ACEs can also aid risk management and quality monitoring.

Doctors who say that we need less of same are wrong. Lawyers who say that we need more of the same are also wrong. What we need is something different and better. An improved system would detect more avoidable injuries, intervene faster to rehabilitate those that occur, send clearer signals about how to prevent injury, and cost far less per case to administer. The best long-run approach would connect concern for avoiding injuries with other monitoring and feedback about quality of care. In the long run, it seems desirable for health plans to take a more active role in monitoring quality of care, promoting prevention of injury, seeking early detection of problems, and intervening promptly when injury does occur—all within a non-litigious framework.

PREPARED STATEMENT OF TROYEN A. BRENNAN

INTRODUCTION

The Harvard Medical Practice Study, carried out under contract to the State of New York, was designed to inform the policy debate now going on in New York and elsewhere about how society can best deal with its medical injuries and malpractice. To do so, we had to understand and isolate the key issues and assumptions that divide the protagonists of the current tort system, a reformed tort system, and no-fault alternatives. We have not prejudged the feasibility of any such no-fault program for injured patients, nor have we endorsed the criticisms that are made about present day malpractice litigation. Rather, we believe we have provided relevant empirical data that will permit informed judgments and sound policy-making concerning this complex area.

The Study had four principal components:

1. A population based measure of the incidence of injuries resulting from medical interventions, which we called "adverse events," and a determination of the percentage of such events that resulted from fault or negligence of the physician or other provider.
2. A determination of the percentage of adverse events, both negligent and non-negligent, that led to claims and suits. In addition, we obtained information about the numbers of claims and suits by patients in whose hospital records we found no evidence of injury.
3. Measures of the costs of medical expenses, lost wages, and lost household production to the victims of medical injuries and to their families, and their compensation for such losses under current arrangements.
4. Estimates of the degree to which variations in the threat of litigation affected the incidence of adverse events.

The following summarizes some of our methods and major findings:

1. The Incidence of Adverse Events

The hospital medical record review was key to estimating the incidence of adverse events associated with medical management. The record review focused on two critical issues: causation and negligence. We asked, "Was the patient's condition attributable to medical management rather than to the disease under treatment (causation)? Was negligence involved?" In addition to establishing causation and negli-

gence, we determined where injuries occurred, the types of injury and then the magnitude of disability experienced. The review was conducted by teams of trained medical record administrators and nurses for the screening phase, and board-certified physicians for the physician-review phase.

In order to make our results generalizable to the entire population of hospital discharges in New York, we drew a probability sample of hospital records. We analyzed 30,121 (96%) of the 31,429 records selected for the study sample. After preliminary screening, physicians reviewed 7,743 records, from which a total of 1,133 adverse events were identified that occurred as a result of medical management in the hospital or required hospitalization for treatment.[1] Of this group, 280 were judged to result from negligent care. Weighting these figures according to the sample plan, we estimated the incidence of adverse events for hospitalizations in New York in 1984 to be 3.7%, or a total of 98,609. Of these, 27.6%, 27,179 cases, or 1.0% of all hospital discharges, were due to negligence.

The majority of adverse events (57%) resulted in minimal and transient disability, but 14% of patients died at least in part as a result of their adverse event, and in another 9% the resultant disability lasted longer than 6 months. Based on these figures, we estimated that about 2,500 cases of permanent total disability resulted from medical injury in New York hospitals in 1984. Further, we found evidence that medical injury contributed at least in part to the deaths of more than 13,000 patients in that year. Many of the deaths, however, occurred in patients who had greatly shortened life expectancies from their underlying diseases. Negligent adverse events resulted, overall, in greater disability than did non-negligent events and were associated with 51% of all deaths from medical injury.

We also studied a series of risk factors for individual patients suffering adverse events, both negligent and non-negligent.[2] The elderly and the uninsured were at greater risk of suffering adverse events due to negligence. None of the other 20 individual factors we incorporated into this model, including gender and race, was significantly associated with higher incidence of negligent adverse events.

At the hospital level, adverse event and negligent adverse event rates varied 10-fold between individual hospitals.[3] Adverse event rates were higher in university teaching hospitals and lower in rural hospitals. On the other hand, the fraction of adverse events due to negligence was lower in university teaching hospitals and higher in hospitals that serve predominantly minority communities.

2. Litigation Data

We estimated that the incidence of malpractice claims filed by patients for the study year was between 2,967 and 3,888.[4] Using these figures, together with the projected statewide number of injuries from medical negligence during the same period, we estimated that eight times as many patients suffered an injury from negligence as filed a malpractice claim in New York State. About 16 times as many patients suffered an injury from negligence as received compensation from the tort system.

These aggregate estimates understate the true size of the gap between the frequency of malpractice claims and the incidence of adverse events caused by negligence. When we identified the malpractice claims actually filed by patients in our sample and reviewed the judgments of our physician reviewers, we found that many cases in litigation were brought by patients in whose records we found no evidence of negligence or even of adverse events. Because the legal system has not yet resolved many of these cases, we do not have the information that would permit an assessment of the success of the tort litigation system in screening out claims with no negligence.

On the other hand, our data reveal that less than 4% of negligent adverse events lead to a suit. Confining our analysis to the adverse events that involved strong or certain evidence of negligence, we estimate that 12,859 injuries from medical negligence did not lead to malpractice claims. Of these injuries, 22% (2,833) occurred in patients under age 70 years who suffered moderate or greater incapacity. Our projections suggest that if this group of patients had litigated, the malpractice claims frequency for year 1984 would have increased by 75%.

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[1] See Brennan TA, Leape LL, Laird NM, et al, Incidence of Adverse Events and Negligence in Hospitalized Patients. New England Journal of Medicine 1991;324:370-6.

[2] See Burstin H, Lipsitz S, Brennan TA, Socioeconomic Status and Risk for Negligent Injury in Hospitals. *Clinical Research* 1991;39:189A.

[3] See Brennan TA, Hebert LE, Laird NM, et al, Hospital Characteristics Associated With Adverse Events and Substandard Care. *JAMA* 1991;265:3265-3269.

[4] See Localio AR, Lawthers AG, Brennan TA, et al, Relation Between Malpractice Claims and Adverse Events Due to Negligence. *New England Journal of Medicine* 1991;325:245-51.

3. Economic Consequences of Medical Injury

Having documented from the medical records survey which patients were injured, and from the litigation survey which patients filed tort suits, we used the patient survey to determine from the patients themselves what losses they suffered as a result of these injuries and what compensation they received from non-tort sources.

Our ultimate finding is that the present discounted value of the net compensable losses (past and future) suffered by patients injured in New York hospitals in 1984 amounted to $1,024 million (in 1989 dollars).[5] These compensable losses consisted of $304 million in lost wages and fringe benefits, $240 million in uninsured medical costs, and $480 million in lost household production (the latter having been valued at the market wages earned by the working women in our patient cohort).

To provide some perspective for these figures, the malpractice premiums paid by New York doctors and hospitals in 1989 amounted to approximately $1.1 billion. These tort costs incorporate two major factors not reflected in our estimate. One is damage for pain and suffering, which typically are not compensated under no-fault programs. The other component is administrative and legal expenses which definitely would be a significant factor over and above the patient's economic losses. The administrative share of claims costs in no-fault workers compensation is usually estimated to be around 20%, though we believe it would be somewhat higher for no-fault patient compensation.

4. Malpractice Litigation and Deterrence

We examined the presumed deterrent effects of the tort system in two ways—a series of physician surveys as well as an econometric study that compared the rates of adverse events and negligent adverse events, on the one hand, with the threat of a claim on the other.

The physician surveys revealed that the overall perceived risk of being sued in a given year was 20%, approximately three times the actual risk of being sued. The perceived risk of suit for negligent care was about 60%, a figure substantially greater than the actual risk of litigation from injuries caused by negligence. Additionally, perceived risk was significantly greater for high-risk specialties such as obstetrics, orthopedics and neurosurgery and for physicians in Nassau and Suffolk counties, lending credence to the responses.

The final part of our study examined the relationship between variations in claims rates and variations in injury rates in the sample of study hospitals. The important test was whether hospitals that face higher claims rates actually do exhibit lower injury rates. Using econometric modeling based on geographic variations in claims rates and injury rates, we found some evidence that there is a deterrent effect of litigation.[6]

CONCLUSION

The Medical Practice Study demonstrates that there are very high levels of patient injuries in hospitals, and a substantial proportion of these are due to negligence. Certain hospitals appear to have much higher rates of such accidents. In addition the elderly and uninsured are at increased risk of being injured due to substandard care. These findings suggest that there is a great need for quality assurance programs that decrease the rates of adverse events, especially those associated with negligence.

Our analysis of litigation records leads one to question the efficacy of malpractice litigation. While there is some evidence it provides a noticeable deterrence signal for health care providers, the mismatch between negligent injuries and suits reveals the haphazard manner in which the system functions, and suggests that the administrative costs associated with it are exceedingly high. Indeed, an analysis of economic costs of injuries indicates that an administrative scheme could compensate all injuries, both negligent and non-negligent, for the amount we now put into the tort system to compensate negligent injuries alone.

Our study team has concluded that it is time to test some alternatives to malpractice litigation. In particular, we believe that replacing tort litigation with a hospital-based administrative compensation scheme that employs a strict liability standard, and relies on sharply experience-rated insurance premiums, would provide more appropriate deterrence signals for providers and better compensate people injured in

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[5] See Johnson WL, Brennan TA, Newhouse JP et al, The Economic Consequences of Medical Injuries: Implications for a No Fault Insurance Plan. (article submitted for publication).

[6] See Weiler PC, Newhouse JP, Brennan TA, Johnson WL, Leape LL, and Hiatt HH, Patient Injury and Malpractice Litigation (book manuscript submitted for publication).

hospitals. An experiment with such an approach in one or several states should be a high priority on the health care research agenda.

PREPARED STATEMENT OF SENATOR PETE V. DOMENICI

I am very pleased to appear before the Subcommittee on Medicare and Long-Term Care to discuss the very important topic of health care costs and our medical liability system. It is very encouraging to see this kind of interest in an area of health care that I believe deserves our priority attention. I want to personally thank the Chairman of this Subcommittee, Senator Rockefeller, and the Ranking Member, Senator Durenberger, for showing leadership in calling this important hearing.

INTRODUCTION—MEDICAL LIABILITY REFORM WILL HELP CONTROL COSTS

The facts about the health care cost explosion are well known but are worth repeating. Last year, the U.S. spent 12.3 percent of Gross National Product (GNP) on health care, up from 5.9 percent in 1965. Projections indicate we will be spending 16.4 percent of our GNP on health care by the turn of the century.

If we let this trend continue, uncontrolled health spending will seriously hinder economic growth. Family, business, and federal and state government budgets are squeezed so tight by rising health costs that we spend less on other pressing needs, such as the education of our children, business research and development, and public infrastructure.

Furthermore, our rising health costs make it difficult for us to compete in the world economy. In 1989, we devoted over twice as much of our productive capacity to health care than did the United Kingdom, 75 percent more than Japan, 40 percent more than former West Germany, and 35 percent more than Canada.

Of course, the exploding cost of health care also contributes significantly to the enormous uninsured population—those thirty four million Americans who do not have health insurance protection. Controlling costs will be central to ensuring these persons can get needed health care services.

In examining what is behind these high costs, it became clear to me that our current medical malpractice system is a large part of the problem.

Physicians and other health providers, fearful of lawsuits, change the way they deliver health care to maximize their ability to defend themselves in front of inexpert juries. They order countless unnecessary diagnostic tests and perform unnecessary procedures because they believe it is expected of them by the court system:

This unnecessary defensive medicine, as well as extremely high medical malpractice insurance costs, adds billions of dollars to our health care bills every year, with little or no additional benefit in terms of quality health care.

I am certainly not alone in this conclusion. The President has shown important leadership in calling for significant reforms of our medical malpractice laws in order to control health care costs, and there is a growing list of Senators and other leaders who support significant reforms. Just last month, the Governors—on a bipartisan basis—urged medical liability reform.

In June, I introduced my own proposal with the endorsement of former Surgeon General C. Everett Koop. This bill, the Medical Injury Compensation Fairness Act of 1991 (S. 1232), has been referred to the Finance Committee for consideration and is cosponsored by Senators Danforth and Chafee of the Finance Committee, as well as by Senators Rudman and Gramm.

DON'T HOLD MEDICAL LIABILITY REFORM HOSTAGE TO COMPREHENSIVE REFORM

Some have suggested that we should only act on medical liability reform in the context of larger, comprehensive health care reform plans. But if we wait for a consensus on large scale reform, it could be years before we make any progress on controlling health care costs and expanding access.

I don't think we should deny the American people some improvements in the health care system now in the hope of more sweeping reforms later.

I understand that Senator Bentsen and others are working on proposals to increase access to health insurance through regulation of the small group market. That may be a promising approach to ensuring protection for more people, but it would not help control the overall costs of health care.

Such an access proposal could be significantly improved if it were coupled with medical liability reform to help hold down the growth in health care costs.

THE CURRENT SYSTEM: AN EXPENSIVE AND INEFFICIENT LOTTERY

The current jury process for deciding medical malpractice cases is like a lottery—a very select few hit the jackpot, usually those with good lawyers or those who have suffered sensational injuries that draw sympathy from juries, even if the injuries are due to adverse events and not physician negligence.

A recent Harvard study has documented the tremendous inequities of this lottery approach:

—80 percent of all suits filed have no evidence of negligent medical care.
—but 15 out of 16 persons injured due to negligent medical care never get compensated through the current litigation system.

So good doctors are sued much more often than they should be, and yet many patients are getting substandard care without any penalty for the physician.

Furthermore, the small chance of hitting the jackpot has induced thousands of frivolous lawsuits. In the 1980s, the number of malpractice lawsuits per 100 physicians more than doubled, from 3.2 to 7.4. Today, nearly 40 percent of all physicians can expect to get sued at some point in their careers, and 50 percent of those performing any kind of surgery. Furthermore, nearly 80 percent of all obstetricians will have a claim filed against them, and the average obstetrician can expect to have 3 claims filed against him during his career.

Physicians and other health providers practice medicine defensively—even if they know it will not benefit the patient—because they want to reduce the chances that somebody can hit the jackpot with a jury in a lawsuit against them. They order countless unnecessary tests and procedures to create the perception for juries that they did everything possible to provide the highest level of care. And they pass along the costs of all this unnecessary care to their patients. Defensive medicine is hard to estimate, but there is no doubt that it is costs tens of billions of dollars a year.

This lottery system is also very costly and inefficient. Senator Rockefeller has stated that only 22 percent of all malpractice insurance premiums actually reach injured patients—the other 78 percent pays for lawyers and other administrative costs.

EXAMPLES

I think a couple of true stories help illustrate what is wrong with today's medical malpractice system.

In a 1986 medical malpractice lawsuit in Philadelphia, a woman alleged that a dye injected for a CAT scan triggered an allergic reaction and severe headaches. She claimed that the headaches impaired her job skills—as a psychic with the power to read auras, conduct seances, and predict the future. The jury deliberated for 45 minutes and awarded her $1 million.

In a March 1990 trial in Florida, experts testified before a jury that a retired police officer suffered loss of memory and sight, deafness, and use of his left leg and arm due to negligence during back surgery. The jury awarded him $2.25 million. One year later, he was seen boarding his new 46 foot yacht, driving to his home in the Florida Keys, and carrying luggage up stairs.

MALPRACTICE INSURANCE PREMIUMS

It is no wonder that malpractice insurance premiums are going through the roof. In the 1980s, malpractice premiums increased at an average annual rate of 15.1 percent, far outpacing the average rate of inflation in overall medical care.

In Florida, obstetricians now pay $150,000 per year in malpractice insurance premiums. In Michigan, they pay $134,000 per year.

These enormous premiums are passed on to the mothers who get prenatal and delivery care—their obstetricians simply charge them more. In many parts of the country, patients cannot afford to pay such inflated bills, so the doctors are quitting their practices.

The number of obstetricians in non-metropolitan areas fell by 20 percent in five years, often because of the high cost of malpractice insurance or concerns about being sued.

A FEDERAL SOLUTION IS JUSTIFIED AND NECESSARY

Some have expressed the concern that Federal medical liability reform legislation would encroach on states' rights and breach Federalism. I believe a Federal reform is not only justified, but necessary.

In 1992, the Federal Government will spend $216 billion directly on health programs, or about 30 percent of all health spending. Moreover. Federal tax subsidies for employer-provided health insurance, which finance another $185 billion in health costs, total $65 billion annually.

With these kinds of expenditures, the Federal Government certainly has a legitimate interest in addressing the legal environment, now controlled by the states, which profoundly affects these costs.

Furthermore, a state-by-state reform approach is unlikely to have the intended effect of reducing defensive medicine. I believe physicians and other health care providers will tend to gravitate to the highest rate of defensive practices. So if only a few states enact significant reforms, physicians in those states may not feel comfortable practicing at a level different from physicians in other states.

THE DOMENICI PROPOSAL: THE MEDICAL INJURY COMPENSATION FAIRNESS ACT OF 1991 (S. 1232)

I applaud the President for coming forward with a proposal because it helped focus attention on this issue, but I do not believe the approach he has taken—penalizing States that do not enact tort reforms—is the answer to the problem.

If we are to significantly reduce defensive medicine, I believe we need to take the more dramatic step of moving these cases out of the courtroom and into binding arbitration. Even if we put some constraints on the awards juries can make, as the President proposes, I believe physicians and other health providers will continue to practice medicine defensively because they will still face endless and expensive court litigation and inexpert juries applying poorly defined standards to their medical decisions.

My bill would require all participants in Federal health programs (Medicare, Medicaid, Veterans3 Health, Military Health programs, Indian Health Service, etc.) to take their cases to binding arbitration. Furthermore, all those who are enrolled in private health plans that are tax deductible to an employer must also take their cases to binding arbitration. We estimate that these two requirements will take 80 percent of malpractice cases out of court. Those not covered by these two requirements could voluntarily agree to take their cases to arbitration instead of court.

Binding arbitration would significantly reduce the time and cost of adjudicating claims, allow more injured patients to get their cases heard, and improve the consistency and accuracy of the decisions for physicians and patients. Liability decisions would be informed by practice guidelines that were incorporated into health plan contracts, thus reducing the uncertainty about what is expected of health care providers.

My bill would also impose many of the same constraints on damage awards that the President proposes, but in the context of arbitration, not litigation. These constraints include: a $250,000 cap on non-economic damages; reduced awards if the injured person is compensated by other insurance coverage; and periodic payments, rather than lump sums, for awards intended to compensate anticipated future losses.

Finally, S. 1232 would redirect payment of punitive damages away from plaintiffs, giving the funds instead to State agencies to improve the disciplining of grossly negligent physicians. This provision would reduce the incentive for plaintiffs to seek the jackpot of huge punitive damage awards while retaining the principle of monetary punishment of clearly negligent care.

CONCLUSION

I am very pleased that this Subcommittee has begun the process of examining this important issue, and I look forward to working with the Committee to advance a sound legislative proposal.

ATTACHMENTS

A Brief Summary of S. 1232

"Sue the Doctor? There's a Better Way," Senator Pete V. Domenici and C. Everett Koop, *The New York Times,* June 6, 1991.

Letters endorsing S. 1232 from C. Everett Koop, Joseph Califano, and the National Federation of Independent Businesses.

S. 1232—MEDICAL INJURY COMPENSATION FAIRNESS ACT OF 1991, SENATOR PETE V. DOMENICI

BRIEF SUMMARY

Purpose: To promote economic growth and provide more reasonable health care costs for consumers and taxpayers by reducing unnecessary defensive medicine; to provider fairer and more timely awards for injured patients and more rational liability decisions for physicians; to provide for efficient resolution of medical injury claims.

Binding Arbitration: Beneficiaries of Federal health programs (Medicare, Medicaid, federal employees health, VA medical, public health service, and other health programs) and tax deductible employer-provided health plans would be required to resolve medical injury claims in arbitration. Others would have the option of agreeing to arbitration when offered by health providers.

Judicial Review: Paralleling the appeal provisions in the Federal Arbitration Act, arbitration decisions could be appealed, on a limited basis, for review by State courts to ensure fair and impartial decisions.

Alternative Dispute Resolution Services: State agencies and/or private entities certified by the Secretary of HHS would be authorized to resolve these disputes. All would offer a standard arbitration approach, but parties to a dispute could agree on alternative procedures.

Constraints on Awards: Non-economic damages would be capped at $250,000; awards would be reduced for collateral source payments for the same injury; and periodic payment would be allowed for awards above $100,000. Economic damages would be fully recoverable.

Punitive Damages: Punitive damages would go to State agencies with plans approved by the Secretary of HHS to improve the monitoring and disciplining of health providers.

Standards for Imposing Liability: Certified (by the Secretary of HHS) medical practice guidelines could be used to establish the appropriate standard of care.

THE NEW YORK TIMES **OP-ED** THURSDAY, JUNE 6, 1991

Sue the Doctor? There's a Better Way

By Pete V. Domenici and C. Everett Koop

WASHINGTON

Under America's medical malpractice system, everyone pays grossly inflated health care bills. President Bush has offered sound remedies for the problem, but more fundamental change is required. Instead, we want to overhaul the system by removing virtually all malpractice claims from courts and resolving them in binding arbitration.

Medical liability insurance was the fastest growing part of patients' bills in the 1980's, increasing by more than 18 percent annually from 1982 through 1988. Today, every $100 paid to a doctor includes $11 for such insurance. In Chicago, neurosurgeons and obstetricians are charged more than $150,000 in premiums, and, like their colleagues elsewhere, pass the costs along to patients.

To protect themselves against potential malpractice suits, physicians order countless unnecessary tests and perform valueless procedures so that they might tell a jury they tried to provide the best care possible. By many accounts, unnecessary care constitutes 20 percent to 25 percent of the nation's health expenditures.

The cost of premiums and outrageously high jury awards have forced physicians in high-risk specialties to quit their practices. The number of obstetricians in non-metropolitan areas fell by 20 percent between 1984 and 1989, denying many pregnant women the services they need.

President Bush, in a bill sent to Congress, is encouraging states to place limits on court awards for non-economic damages such as pain and suffering and to set up a mediation system for resolving disputes. Non-complying states would find their Federal Medicare and Medicaid aid reduced.

If insurance costs are reduced and defensive medicine is curtailed, health care costs can come down and more of the 34 million uninsured Americans will be able to gain access to health care.

We think far-reaching changes, proposed in legislation to be submitted to the Senate today, are necessary.

First, participants in all Federal health programs must resolve medical injury claims in binding arbitration instead of in court. These participants include beneficiaries of Medicare, Medicaid, Federal employees' health plans, and public health and veterans' programs. Second, employees of all companies that get a tax break by offering health plans must resolve medical liability disputes in binding arbitration as well.

Take the case to binding arbitration.

This legislation would take about 80 percent of all medical injury claims out of court. (It would not apply to the uninsured and self-employed.)

Mr. Bush wants the following worthy restrictions imposed on state courts: a $250,000 cap on awards for non-economic damages; reduced awards if the injured person is compensated by other insurance coverage, and periodic payments, rather than lump sums, for awards intended to compensate a person for anticipated losses. We think these limits should apply in binding arbitration, bypassing the courts entirely.

Under today's litigation system, 15 out of 16 people victimized by a doctor are never compensated.

Sixty percent of the cost of malpractice insurance pays lawyers' fees and administrative costs, leaving 40 percent for patients. Even worse, patients wait years for compensation. In Michigan, court litigation takes nearly three years; voluntary arbitration, about half that time.

The Senate bill would encourage Federal and state governments, medical societies and other organizations to develop guidelines that arbitrators could use to define standards of medical treatment.

Under mandatory nationwide arbitration, patients and physicians would get more consistent, more expert, more reasonable and more timely decisions. This would not only be good for health care, but also the money Americans save from reduced health care bills could be used to benefit the economy. □

Pete V. Domenici of New Mexico is ranking Republican on the Senate Budget Committee. C. Everett Koop was Surgeon General.

June 6, 1991

Honorable Pete V. Domenici
United States Senate
434 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Domenici:

I want to commend you for your proposal to reform the medical liability system in this country. Your bill would provide more reasonable health care costs for consumers, fairer and more timely awards for injured patients and more rational liability decisions for physicians.

As you know, the current medical liability system has many flaws, including the inducement of costly defensive medicine. Some estimates indicate that as much as 25 percent of health expenditures are unnecessary, and defensive medicine is responsible for much of these costs. We cannot afford to continue spending hundreds of billions of dollars needlessly on health care if we are to have resources available for other important needs, like providing health care for those who don't have it and educating our children.

Furthermore, the current medical liability system is unfair for many patients. As many as 15 out of 16 persons who have been injured due to negligent medical treatment never get compensation through the litigation system, and 60 percent of malpractice insurance premiums pay for administrative expenses and lawyers' fees, leaving only 40 percent for injured patients.

To address these problems, I am convinced that we need to take these cases out of court and resolve them instead in arbitration-type arrangements with some constraints on awards. Your bill would do just that. It would also give health care consumers and providers the flexibility to agree early on about dispute resolution arrangements specific to their needs.

I also applaud those provisions in your bill which encourage the development and use of practice guidelines to help determine the appropriate standard of care in specific situations. These guidelines can help eliminate the confusion of opposing expert witnesses presenting conflicting opinions on the appropriate standards.

Again, I congratulate you for developing this excellent piece of legislation. I believe it is critical that we move quickly to address the obvious failings of the current liability system, and I fully support the approach you have taken in your bill. I look forward to helping you advance this important proposal.

Sincerely,

C. Everett Koop, M.D.

JOSEPH A. CALIFANO, JR.

June 5, 1991

The Honorable Pete V. Domenici
United States Senate
427 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Domenici:

Your proposal to reform the medical malpractice system wisely builds upon the legitimate Federal interest in reducing escalating health costs.

There are many unnecessary costs associated with our current health care system, including billions of dollars in unnecessary defensive medicine. In order to expand access and more efficiently use the $750 billion Americans will spend on health care this year, we must begin to make changes in many areas, including our medical malpractice system. We have the resources to provide health care to all Americans, if we free up funds that are being needlessly spent.

Using Federal programs to spur medical liability reform is appropriate. The Federal government spends $220 billion directly on health care. Federal subsidies for private health insurance, which finances another $185 billion in health care, exceed $50 billion annually. The current malpractice system is inefficient. Sixty percent of malpractice insurance premiums pay lawyer's fees and administrative costs for malpractice cases. That leaves only forty percent for those people who are injured. Your bill would correct this inequity and give more to injured patients.

I applaud the provisions in your bill that encourage the development of practice guidelines for physicians. Standards of care for physicians offer the promise of higher quality medical care for patients, as well as a fair defense against charges of malpractice.

Your legislation is an excellent step towards making health care in our nation more effective and efficient.

Sincerely,

Joseph A. Califano, Jr.

NFIB

National Federation of
Independent Business

June 5, 1991

Honorable Pete Domenici
United States Senate
Washington, DC 20510

Dear Senator Domenici:

On behalf of the over 500,000 small business members of the National Federation of Independent Business, I want to thank you for introducing the Medical Injury Compensation Fairness Act of 1991.

The high price of health insurance is the primary barrier small business owners face when trying to set up health care coverage for their employees, and health care costs continue to spiral upward, threatening continued coverage. Between 1987 and 1990, small business health insurance premiums rose from an average of $1,942 per employee to $3,192 per employee.

The Small Business Administration has estimated that the threat of malpractice claims adds $4 billion to the cost of health care each year and that defensive action on the part of doctors costs $100,000 per year per physician. By virtually eliminating multi-million dollar jury awards, the Medical Injury Compensation Fairness Act of 1991 could limit the need for physicians to practice defensive medicine. With health care costs skyrocketing, this country can no longer afford the millions of useless tests doctors currently perform to protect themselves from malpractice suits.

One of NFIB's top priorities is to reduce the cost of health insurance in this country so that small business owners can afford to purchase it for their employees and for themselves. The Medical Injury Compensation Fairness Act could help bring down the cost of health care by reducing the cost of medical malpractice suits, lowering medical malpractice insurance and reducing the practice of defensive medicine.

Again, thank you for introducing this important legislation.

Sincerely,

John J. Motley III
Vice President
Federal Governmental Relations

kc/DJG

Suite 700
600 Maryland Ave. S.W.
Washington, DC 20024
(202) 554-9000
Fax (202) 554-0496

102D CONGRESS
1ST SESSION

S. 1232

To provide for medical injury compensation reform for health care provided under the Social Security Act and other Federal health programs, to amend the Internal Revenue Code of 1986 to implement like reforms in employer-provided health plans, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 6 (legislative day, JUNE 3), 1991

Mr. DOMENICI (for himself, Mr. DANFORTH, Mr. RUDMAN, Mr. CHAFEE, and Mr. GRAMM) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To provide for medical injury compensation reform for health care provided under the Social Security Act and other Federal health programs, to amend the Internal Revenue Code of 1986 to implement like reforms in employer-provided health plans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medical Injury Compensation Fairness Act of 1991".

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress finds that—

(1) health care expenditures are escalating beyond the ability of Americans to afford them, having increased from 5.9 percent of gross national product in 1965 to over 12 percent in 1990;

(2) the medical injury compensation system currently in effect in the United States is ineffectual in compensating injured persons, has very high administrative costs, and contributes to the high level of unnecessary spending on health care;

(3) as many as 15 out of 16 persons injured due to medical negligence never get compensation through the current medical malpractice system;

(4) malpractice insurance premiums, only 40 percent of which ever reach injured persons as compensation for their injuries, increased at an average rate of 18.3 percent per year from 1982 to 1988;

(5) unnecessary defensive medical practices, rendered by physicians in anticipation of juries' retrospective application of poorly specified standards of care to their diagnostic and treatment choices, add billions of dollars to the Nation's health care bill;

(6) the law governing medical malpractice operates to limit access to health care by driving costs to unaffordable levels and by discouraging physicians

from treating high-risk patients and from practicing in high-risk areas and specialties; and

(7) the Federal Government, which directly finances about 30 percent of the health care consumed in the United States and subsidizes a substantial portion of private health insurance, has a legitimate financial interest in addressing the problems associated with the current medical malpractice system.

(b) PURPOSE.—It is the purpose of this Act to—

(1) encourage the efficient resolution of medical injury claims, using alternative methods of dispute resolution;

(2) ensure fairness in the awards granted in medical injury cases;

(3) reduce inappropriate, unnecessary or defensive medical practices;

(4) reduce public and private health care costs;

(5) improve access to health care; and

(6) facilitate informed, responsible choices in the selection of alternative methods of dispute resolution and in the specification of appropriate standards for medical practice.

SEC. 3. FEDERAL MEDICAL DISPUTE RESOLUTION PROGRAM.

(a) AGREEMENT TO PARTICIPATE.—Any person accepting or providing health care to be paid for, in whole or in part, directly or indirectly, with funds made available under the Social Security Act, the Public Health Service Act, or any other Federal Act shall be deemed to have agreed to participate in the Federal medical dispute resolution program established under this Act for the purpose of fairly and quickly resolving claims against health care providers for personal injury arising from care rendered under such Acts. Such agreement to participate shall be binding on any person making such a claim and shall be enforceable in any court of competent jurisdiction.

(b) MANDATORY RESOLUTION OF CLAIMS THROUGH CERTIFIED DISPUTE RESOLUTION SERVICE.—

(1) REQUIREMENT.—When an agreement is deemed to exist under subsection (a), any claim of the type referred to in that subsection that is not settled voluntarily by the parties thereto shall be resolved only through a dispute resolution service that has been certified under section 6.

(2) PROCEDURES.—A person having a claim of the type referred to in subsection (a) may initiate the procedures to resolve such claim through a dispute resolution service by—

(A) filing a claim with a dispute resolution service then appearing on the applicable list of such services maintained by the Secretary of Health and Human Services under section 6; and

(B) providing notice of such filing (pursuant to regulations prescribed by the Secretary of Health and Human Service) to the provider or providers against whom the claim is made.

(3) AGREEMENT TO USE SPECIFIC SERVICE.—If the person filing a claim under this section and the provider against whom such claim is filed agree or have previously agreed to use a particular dispute resolution service to resolve such claim, the claim shall be filed with that service.

(4) CLAIMS AGAINST MORE THAN ONE PROVIDER.—If a claim is made against more than one provider, such providers shall have not more than 30 days to agree that the claim will be resolved by any dispute resolution service to which the claimant has agreed with any one of such providers.

(5) RESOLUTION.—Once properly filed, a claim under this section shall be resolved by the dispute resolution service selected, under procedures prescribed by such service. The decision of the dispute

resolution service with respect to a claim under this section shall be final and not subject to further review by any court, except that a party to a dispute may obtain review of the decision on any of the following grounds in any court of competent jurisdiction in the State wherein the decision was made:

(A) The award was procured by corruption, fraud, or other undue means.

(B) There was evident partiality or corruption on the part of the arbiter.

(C) The arbiter was guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy, or of any misbehavior by which the rights of any party were prejudiced.

(D) The arbiter exceeded its powers or so imperfectly executed them that a final and definite award upon the claim was not made.

Where an award is vacated under this paragraph, the court shall direct that the matter shall be reheard by another arbiter under the procedures prescribed by the dispute resolution service.

(c) LIMITATIONS.—No claim of the type referred to in subsection (a) may be filed with a dispute resolution

service after the expiration of any applicable time limitation as prescribed in State law, and in no event, except in the case of fraudulent concealment of relevant facts by the provider against whom the claim is made, may such a claim be brought in any forum more than 8 years after the date of the occurrence of the incident that gave rise to the claim.

(d) STANDARDS FOR IMPOSING LIABILITY.—Liability for any claim that is subject to resolution under subsection (b) shall be determined under the standard of care prescribed under applicable State law, except that the Secretary of Health and Human Services may determine (and announce in the Federal Register), and any organized health plan in which beneficiaries may voluntarily enroll may provide by contract, that—

(1) particular services shall be rendered in accordance with identified medical practice guidelines that have been certified pursuant to section 6(b), in which case such guidelines shall, to the extent applicable, be deemed to supply the standard of care to be employed in determining liability (the Secretary may determine that geographic or other factors affecting the availability of resources to meet health care needs may warrant some variation from an oth-

erwise uniform standard supplied by such guidelines);

(2) any expert witnesses testifying as to whether the applicable standard of care was met must possess specified qualifications; or

(3) certain personal injuries and other losses resulting from specified services or procedures shall be compensated without regard to provider fault if such alternative method of compensation has been certified by the Secretary pursuant to section 6(b).

(e) DAMAGES.—When a claim that is subject to resolution under subsection (b) results in a finding of liability, the damages awarded to the claimant shall be determined and awarded as follows—

(1) awards for noneconomic damages shall be limited to $250,000 (including any punitive damages if such damages are not paid to the State pursuant to paragraph (4)) except in the case of a claim arising in a State that has a lesser limit on such damages in which case such State limit shall apply;

(2) awards shall be reduced for any collateral source payments to which the patient is entitled for the medical injury for which the claim was filed;

(3) in the case of an award in excess of $100,000, claimants shall accept periodic payment

of the amount of such awards that are intended to compensate the claimant for damages expected to be incurred in the future such as lost income and medical expenses; and

(4) an award of punitive damages shall not be paid to the claimant, but shall instead be paid to the State if the State has submitted a plan to the Secretary of Health and Human Services, and the Secretary has approved such a plan, to use such funds to improve the monitoring, disciplining, and educating of health care providers in the State to ensure they meet standards of competency.

(f) COSTS.—The party against whom a claim, that is subject to resolution under subsection (b), is substantially resolved (an issue to be expressly determined in resolving the dispute) shall pay the charges assessed by the dispute resolution service for resolving the claim (if any such charges are assessed), except that—

(1) any such charges payable by the claimant shall be paid in fact by the claimant's attorney if such attorney's fee for representing the claimant is contingent in whole or in part on achieving a successful outcome; and

(2) a claimant who is not represented by an attorney and who demonstrates an inability to pay

such charges (according to criteria specified by the Secretary in regulations) shall be entitled to have liability for such charges (including any filing fees) waived by the dispute resolution service.

SEC. 4. MEDICAL DISPUTE RESOLUTION IN EMPLOYER-PROVIDED HEALTH CARE PLANS.

Section 162 of the Internal Revenue Code of 1986 (relating to trade or business expenses) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following new subsection:

"(m) MEDICAL DISPUTE RESOLUTION REQUIREMENTS IN HEALTH CARE PLANS.—

"(1) IN GENERAL.—No deduction shall be allowed under this chapter for expenses paid or incurred by an employer for any health plan (whether or not self-insured) maintained by the employer for the benefit of employees unless the employees covered by such plan have entered into agreements meeting the requirements of paragraph (2) for the purpose of fairly and quickly resolving claims against health care providers for personal injury arising from care rendered under such plan. Such agreements shall be deemed to bind any person making such a claim and shall be enforceable in any court of competent jurisdiction.

"(2) MANDATORY RESOLUTION OF CLAIMS THROUGH A CERTIFIED DISPUTE RESOLUTION SERVICE.—Agreements referred to in paragraph (1) shall—

"(A) provide that—

"(i) any claim of the type referred to in paragraph (1) that is not settled voluntarily by the parties thereto shall be resolved through a dispute resolution service that has been certified under section 6 of the Medical Injury Compensation Fairness Act of 1991 under procedures prescribed by such service;

"(ii) the decision of the dispute resolution service shall be final and not subject to further review by any court, except that a party to a dispute may obtain review of the decision on any of the following grounds in any court of competent jurisdiction in the State wherein the decision was made—

"(I) the award was procured by corruption, fraud, or other undue means;

"(II) there was evident partiality or corruption on the part of the arbiter;

"(III) the arbiter was guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy, or of any misbehavior by which the rights of any party were prejudiced;

"(IV) the arbiter exceeded its powers or so imperfectly executed them that a final and definite award upon the claim was not made; and

"(iii) where an award is vacated on any of the grounds specified in clause (ii), the court shall direct that the matter shall be reheard by another arbiter under the procedures prescribed by the dispute resolution service;

"(B) provide that no claim of the type referred to in paragraph (1) may be filed with a dispute resolution service after the expiration of any applicable time limitation under State law

and further provide that in no event, except in the case of fraudulent concealment of relevant facts by the provider against whom the claim is made, may such a claim be brought in any forum more than 8 years after the occurrence of the incident that gave rise to the claim;

"(C) provide that any such claim shall be initiated as follows—

"(i) a person having such a claim shall initiate it by filing such claim with a dispute resolution service then appearing on the applicable list of such services maintained by the Secretary of Health and Human Services pursuant to section 6 of the Medical Injury Compensation Fairness Act of 1991 and providing notice of such filing (pursuant to regulations prescribed by such Secretary) to the provider or providers against whom the claim is made;

"(ii) if the injured person and the provider against whom the claim is filed have agreed, or have previously agreed, to use a particular dispute resolution service to resolve such claims, the claim shall be filed with that service; and

"(iii) if the claim is made against more than one provider, such providers shall have not more than 30 days to agree that the claim will be resolved by any dispute resolution service to which the claimant has agreed with any one of them;

"(D) provide that liability for any claim that is subject to resolution pursuant to subparagraph (A) shall be determined under the standard of care prescribed in applicable State law, except that—

"(i) the agreement may instead specify an alternative standard to govern care rendered under the plan or specify the qualifications of expert witnesses who will be permitted to testify as to whether the applicable standard was met in a given case;

"(ii) if the employees' agreement with the plan provides that particular services will be rendered in accordance with identified medical practice guidelines that have been certified by the Secretary of Health and Human Services pursuant to section 6 of the Medical Injury Compensation Fair-

ness Act of 1991, such guidelines shall, to the extent applicable, be deemed to supply the standard of care to be employed in determining liability; or

"(iii) the agreement may instead specify an alternative method of compensating, without regard to provider fault, personal injuries that result from care rendered under the plan, if such alternative method of compensation has been certified by the Secretary pursuant to section 6 of the Medical Injury Compensation Fairness Act of 1991;

"(E) provide that when any claim that is subject to resolution pursuant to subparagraph (A) results in a finding of liability, the damages awarded to the claimant shall be determined and awarded in accordance with section 3(e) of the Medical Injury Compensation Fairness Act of 1991, except that employees agreeing in plans to alternative damage award arrangements that are not inconsistent with such section 3(e), or do not result in greater damage awards than could occur under such section

3(e), shall be awarded damages consistent with such alternative arrangements; and

"(F) provide that the party against whom a claim subject to resolution under subparagraph (A) is substantially resolved (an issue to be expressly determined in resolving the dispute) shall pay the charges of the dispute resolution service for resolving the claim (if any such charges are made), except that—

"(i) any such charges payable by the claimant shall be paid in fact by the claimant's attorney if such attorney's fee for representing the claimant is contingent in whole or in part on achieving a successful outcome; and

"(ii) a claimant who is not represented by an attorney and who demonstrates an inability to pay such charges (according to criteria specified by the Secretary in regulations) shall be entitled to have liability for such charges (including any filing fees) waived by the dispute resolution service.".

SEC. 5. HEALTH CARE NOT COVERED BY SECTIONS 3 OR 4.

(a) STANDARD NOTICE AND CONTRACT.—The Secretary of Health and Human Services shall develop—

(1) a standard notice form to provide information to persons regarding their option to voluntarily enter into agreements with health care providers to resolve medical injury claims arising from the provision of health care by such providers in a manner consistent with the requirements of section 3; and

(2) a standard contract that would serve as the basis for such voluntary agreements.

(b) GOOD FAITH EFFORT.—As a condition of eligibility for reimbursement under titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 and 1396 et seq.), health care providers shall make a good faith effort to enter into agreements with persons not subject to the medical injury compensation reforms contained in section 3 of this Act or section 162(m) of the Internal Revenue Code of 1986 to provide for the resolution of medical injury claims arising from the provision of such health care in a manner consistent with the requirements of section 3 using the standard contract developed pursuant to subsection (a) and after providing the standard notice developed pursuant to subsection (a).

(c) VALID CONTRACTS.—Contracts entered into in accordance with subsection (b) shall be deemed to be bind-

ing and valid contracts in all courts of competent jurisdiction.

SEC. 6. CERTIFICATION.

(a) ALTERNATIVE DISPUTE RESOLUTION SERVICES.—Not later than 12 months after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate regulations that establish the criteria and procedures by which the Secretary (or persons to whom the Secretary has delegated such authority) will determine whether or not to certify an alternative dispute resolution service, except that the Secretary may waive such criteria and procedures in certifying dispute resolution services sponsored by the States. The regulations shall include (but are not limited to) provisions requiring such services to—

(1) have procedures in place for providing to the Federal and State agencies responsible for monitoring or disciplining health care providers standardized information and data regarding evidence of medical injury and the causes of such injuries;

(2) maintain a roster of qualified and independent arbitrators willing to resolve medical injury disputes pursuant to the rules established by the service;

(3) demonstrate neutrality by disclosing funding sources and selection methods used for obtaining arbitrators in resolving medical injury disputes;

(4) demonstrate administrative expertise and an ability to conduct dispute resolution procedures that is consistent with a basic dispute resolution procedure which shall include—

(A) decisionmaking by a three person arbitration panel with expertise in medical injury disputes;

(B) a period to permit the discovery of evidence;

(C) the right to a hearing;

(D) the right to a decision not later than 6 months after the date on which the claim was filed; and

(E) the right to a written decision; and

(5) require administrative expertise and an ability to advise parties to a dispute regarding alternatives to the basic dispute resolution approach and to carry out such alternative procedures if all parties to a dispute agree to one of the alternative procedures.

(b) STANDARDS FOR IMPOSING LIABILITY.—Not later than 12 months after the date of enactment of this

Act, the Secretary of Health and Human Services shall promulgate regulations that—

(1) establish the criteria to be used for the certification of medical practice guidelines by the Secretary (or persons to whom the Secretary has delegated such authority), including criteria to ensure that such guidelines—

(A) reflect up-to-date scientific learning and the judgment of objective experts;

(B) are supported by proper documentation; and

(C) are accompanied by justifications for the standards established; and

(2) establish the criteria to be used for the certification by the Secretary (or persons to whom the Secretary has delegated such authority) of alternative methods of compensating personal injuries and other losses without regard to provider fault, including criteria to ensure that such alternative methods would—

(A) be administered fairly and efficiently;

(B) preserve incentives to maintain the quality of care; and

(C) generally give health care consumers financial protection that is at least comparable,

on an actuarial basis, to the legal protections they would otherwise enjoy.

(c) OTHER REGULATIONS.—Not later than 12 months after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate other regulations necessary to carry out this Act.

SEC. 7. RELATION TO OTHER LAWS.

The procedures required under this Act for fairly and quickly resolving claims against health care providers for personal injury shall be exclusive, and no action seeking recovery for any personal injury covered by this Act shall be permitted in any State or Federal court except as expressly provided herein.

SEC. 8. EFFECTIVE DATE.

(a) IN GENERAL.—The provisions of this Act, and the amendments made by this Act, shall apply to health care that is provided after the date that occurs 6 months after the month in which final regulations are prescribed under section 6.

(b) COLLECTIVE BARGAINING AGREEMENTS.—The provisions of section 3 and section 162(m) of the Internal Revenue Code of 1986 shall apply to health care plans provided as part of collective bargaining agreements.

PREPARED STATEMENT OF KAREN S. FENNELL

The American College of Nurse-Midwives (ACNM) is the professional association of certified nurse-midwives (CNMs). The College is pleased to have this opportunity to comment on medical malpractice liability and its impact on the nation's health care costs and access to health care for pregnant women.

There are approximately 4000 certified nurse-midwives in the United States. Certified nurse-midwives work interdependently with physicians with whom they consult and to whom they refer patients who develop complications requiring physician care.

DETAILS OF RECENT INSURANCE CRISIS

Since the passage of the Risk Retention Act of 1986, numerous risk retention groups have offered professional medical malpractice liability insurance to CNMs through their employers. For the most part, these are risk retention groups that insure hospitals and physicians. Premium costs range from $4,000 to $25,000 per year per nurse-midwife.

The other portion of our membership has sought assistance through the College to insure their practices. These CNMs work in community health centers, rural areas of the country, and may own their own professional businesses.

CNA Insurance Companies has offered a claims-made policy to CNMs since 1986. A claims-made policy is priced so that each year you pay for protection against claims which may be reported during that year---in a pay-as-you-go system. Your first year's premium is lower than subsequent premiums because of the decreased probability that all claims resulting from treatment rendered during the first year will be reported by patients that same year.

When the policy is renewed for a second year, the exposure period covered under the policy expands and the premium increases accordingly. The second-year premium consists of (1) the premium needed to cover any claims reported and occurring in the second year of coverage, and (2) the premiums for any claims which are reported in the second year from treatment which occurred during the first coverage year.

Premiums continue to increase annually until a "mature" level is reached. The CNA "mature" level premium is currently $6,100 per year for CNMs.

This year, CNA Insurance Companies notified the College that they did not wish to continue coverage of CNMs since the business was not "profitable". While the number of claims has not increased significantly, the severity of reported payments has escalated 10 fold. It is not unusual for a settlement of $1 million to be paid.

In our search for an underwriter to replace CNA, we have found none to date. AIG, Interstate, St Paul, TransAmerica, and Reliance have declined the program. We have been told by the insurance industry that their commitment to profitability on the program could be difficult to support because of "the political and emotional nature of this class."

In response to our lack of success in obtaining another underwriter, CNA Insurance Companies is willing to renew the program with an overall 46.8% increase in premiums. This will bring the average CNM premium payment to $8,954. CNMs whose average income is $37,000 will find it very difficult to pay for this coverage. CNA has also set as a condition of the renewed terms, an exclusion on all policies specifically excluding home deliveries. This will be a great hardship on rural and frontier America where community hospitals and birthing centers are not located in close proximity to the pregnant woman.

FEDERAL REIMBURSEMENT POLICIES

MEDICARE

ACNM has supported, and continues to support the development of rational systems for reimbursement in both the private and public delivery of health care. We believe that the proposed Medicare reimbursement, if implemented, will adversely affect access to health care for women.

While CNMs take care of relatively few women whose services are paid for by Medicare, Medicare policies set the "Golden Rule" by which other third party payers, including Medicaid, reimburse CNM services. Therefore, we urge you to pay special attention to the impact of the new system on obstetrical services. The proposed Medicare fee schedule is lower than those payments made to CNMs in 1987, and much lower than the average Medicaid or private insurance payment.

We support the resource based relative value scale payment system in theory, except as it relates to professional liability expense. We oppose a system based on a national average professional liability expense of each specialty that provides the particular service.

ACNM supports the use of a direct payment rather than incorporating liability costs into the fee schedule. Giving the individual CNM a lump sum payment from Medicare to cover the program's portion of his or her liability expenses is the only way CNMs and employers will be reimbursed appropriately for professional liability costs involved in providing such care.

Premiums for professional liability for our specialty, like obstetricians, are among the most expensive, and have the most extreme premium variations among states. Premiums can also vary significantly within a state or city between liability carriers. By way of example, in New York State, the cost of a $1 million/$3 million claims-made policy varies from $8,000 to $25,000.

PAYMENT TO COMMUNITY HEALTH CENTERS

Payments to community health centers are inadequate to pay the costs of obtaining liability insurance for CNMs. The College recommends that CNMs employed by community health centers be covered by the Federal Tort Claims Act.

SURCHARGE

My name is Susan M. Jenkins. I practice law in the District of Columbia. Most of my clients are health professionals or their professional associations, who have problems with practice-related issues such as reimbursement, hospital privileges, or restraints of trade. I served as a staff attorney in the Bureau of Competition of the Federal Trade Commission during the Carter administration and have been in private practice dealing with health law and antitrust law for the past ten years. Thank you for providing an opportunity to testify before you on the matter of insurance surcharges, a matter which is of great concern to health professionals and their patients.

The American College of Nurse-Midwives asked me to testify today along with Ms. Fennell because of the experience I have had with the problem of insurance surcharges imposed by physician-owned malpractice insurance companies upon physicians who practice in a collaborative relationship with certified nurse-midwives (CNMs). As members of the Committee may be aware from coverage of this matter in the local D.C. media last month, I currently represent a group practice of OB/GYNs and nurse-midwives who have challenged, before D.C.'s Office of Insurance Administration, the imposition of a 4400 percent rate increase in

the form of a surcharge upon the group's malpractice insurance. This is not, however, an isolated incident, unique only to the District of Columbia. Whether the collaborative relationship between a physician and nurse-midwife takes the form of employment or a contractual arrangement for consultation and referral, health professionals involved in these relationships have, in recent years, been confronted with the imposition of onerous insurance charges which threaten the future of nurse-midwifery practice.

The matter in which my clients are involved is presently pending before the D.C. Superintendent of Insurance, following a two-day public hearing. I will therefore confine my testimony regarding this case to matters which are on the public record. The insurance company in this case is the National Capital Reciprocal Insurance Company (NCRIC) and its underwriter, National Capital Underwriters, Inc. (NCUI). These entities were established in 1980 by the D.C. Medical Society and are wholly-owned and controlled by physicians. NCRIC has a virtual monopoly over malpractice insurance for physicians in the District of Columbia. Similar cases have arisen in other states, involving not only nurse-midwives but also other advanced registered nurse practitioners such as nurse anesthetists. In all such cases, the insurer was owned by doctors. Before getting into any specific case, however, I believe that some background in necessary.

Physician/Nurse-Midwife Clinical Relationships. The ACNM's Standards of Practice provide that nurse-midwives must practice in a setting which provides for consultation with and referral to a physician. For ease of reference, I will refer to such relationships as "collaboration." Most state licensure laws which govern the scope of practice of CNMs within their respective jurisdictions require some form of collaboration. For example, in D.C., the statute specifies what is termed "general collaboration" between an OB/GYN and a CNM, which means that the OB/GYN must be available by telephone or beeper. D.C. Code, sections 2-3301.1; 2-3306.1 et seq. D.C. law also requires that the OB/GYN and CNM develop and abide by written protocols which govern the relationship between them. Some states, like Maryland, require that the protocol be filed with the state board of nursing. Additionally, many hospitals at which CNMs practice may require that the protocols be filed with the obstetrics department or may have instituted regulations governing nurse-midwifery practice which require some mechanism for consultation and referral. Nurse-midwife practice is, thus, an interdependent one with a physician.

No state law, however, requires that a CNM must be employed by a physician. The economic aspects of CNM collaborative relationships are broadly varied, ranging from private practice to employment by a physician to employment by a hospital or HMO to various government or other clinical settings. One constant in these different economic settings is the clinical requirement of consultation and referral arrangements with a physician. This fact of clinical collaboration, of interdependence, even where no economic relationship exists, inevitably gives rise to questions concerning the legal issue of the vicarious liability of each party for the other's negligence.

Vicarious Liability. This issue is complex. Since the basis for vicarious liability is largely a matter of state tort law, the answer will vary in each of the fifty-one jurisdictions in the United States. Several generalizations are possible, however, based on trends which seem to be emerging in the decisions of state appellate courts. These trends include:

1. An employer is almost always liable for the negligent acts of the employee, under the tort doctrine of respondeat superior.

2. The old "captain of the ship" doctrine, which held the physician liable for the negligent acts of all other health professionals (who the law once assumed to be under the physician's control) has been greatly eroded and has little vitality today.

3. When an independent contractor relationship exists between a physician and non-physician health professional, vicarious liability is by no means automatic. Rather, such claims are subjected to a highly fact-intensive analysis of the relationship itself and the actions of each party in relation to the injury suffered by the patient. This is a case-by-case factual process, often a jury question. Vicarious liability is no longer presumed.

One must, of course, recognize that in malpractice lawsuits the plaintiff's attorney is likely to name all health care providers in the initial complaint. But the evolution of this field of law means that the result when vicarious liability is the basis for the claim is no longer a foregone conclusion, but is always a question of fact. Vicarious liability should be distinguished from the direct liability of the physician for his or her own acts. Negligence by the physician in the context of a collaborative relationship does not give rise to vicarious liability but, rather, to direct liability for that negligence.

Insurance Company Reaction. This leads to the question of surcharges. By this term I mean premiums imposed by a malpractice insurance company upon physicians, who employ or otherwise collaborate with a nurse-midwife, in order to provide coverage for the physician for so-called vicarious liability claims against him or her that may be based upon the alleged negligence of the nurse-midwife. These premiums may be flat rates or may be based upon a percentage of the premium paid for the physician's direct coverage. In my own practice, I have observed that certain insurance companies -- almost always companies that are owned by physicians -- have assumed without any justification that any collaborative relationship between a physician and a non-physician health professional will give rise automatically to risks of vicarious liability on the part of the physician. Once this assumption is made, the insurance company may seek to impose a surcharge on the physician to cover this alleged risk, which is what happened in D.C.

The D.C. Case: NCRIC. My client is a group practice of five OB/GYNs. For the past five years, they have employed three nurse-midwives. No claim has been filed against them premised upon the alleged negligence of a nurse-midwife. During most of this period, the practice has purchased its malpractice insurance from NCRIC, the insurance company owned by the D.C. Medical Society. Because NCRIC does not provide direct coverage for non-physicians, my clients have also purchased direct coverage for the CNMs through the ACNM plan. Everyone in the group, including the professional corporation itself, has direct coverage.

When NCRIC renewed their insurance for 1990, it assessed a surcharge for vicarious liability for acts of the nurse-midwives. The surcharge was $ 305 each, for a total of $ 915. Since this was a relatively small amount, my clients paid it without question. However, in December 1990, when they sought to renew this policy for another year, they learned that the vicarious liability surcharge was being increased to $ 13,575 for each

nurse-midwife, which represents 25 percent of the rate for each physician's direct coverage. These 1991 rates also represented an increase of 4400 percent over the previous year for the same coverage. In January, my client paid NCRIC, under protest, a surcharge of over forty thousand dollars.

This group practice retained me to file a complaint with the D.C. Office of Insurance Administration regarding this increase. The D.C. Chapter of the ACNM joined in that protest. On January 31, 1991, both parties filed Joint Comments, with extensive documentary exhibits, protesting the rates. The D.C. Chapter also specifically opposed certain restrictions NCRIC attempted to impose on CNM practice, which would require that all deliveries must take place in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and that the physician must be physically present in the facility during labor and delivery. Since JCAHO does not accredit birthing centers, this would effectively outlaw such centers, as well as home births, in D.C., because if NCRIC's conditions were not met, the physician would not be covered. Copies of these Comments will be provided if the members of the Committee so desire.

In May 1991, both parties were granted formal status as Intervenors in the proceedings of the Office of Insurance Administration. A public hearing was held on September 6 and 13 before the Superintendent of Insurance, at which NCRIC and the Intervenors presented written and oral testimony and documentary exhibits, and cross-examined each other's witnesses. The transcript of the hearing record is over 500 pages long and can also be provided if the committee so desires. From these proceedings, we have learned a great deal about the nature of the problems in the insurance industry in dealing with nurse-midwives and other health professionals, which Congress may be able to help resolve. The problems present themselves in this way:

1. Data collection. The insurance industry at present does not collect data in any actuarial form which distinguishes between claims against a physician for his or her own negligence and claims premised upon vicarious liability for the negligence of another, whether that other is an employee or an independent contractor. Various organizations within the insurance industry collect claim and loss data, which are then analyzed by actuaries and made available to insurance companies to use in developing and setting rates. Most prominent among these organizations is the Insurance Service Office (ISO), which is a cross between a trade association and a rating bureau in the commercial insurance industry. Data are also collected and disseminated by the Physicians Insurance Association of America (PIAA), a trade association of physician-owned insurers, and by certain private consulting actuaries. Such data in the malpractice insurance field are collected, classified, and reported by physician specialty. Each specialty is considered a primary classification. Thus, there are national data regarding total claims against OB/GYNs as a class. These data do not, however, tell us whether these claims were based upon direct or upon vicarious liability.

2. Premium rates. Since the data do not reveal whether claims were direct or vicarious, no insurer can distinguish what percentage, if any, of such claims reflect vicarious liability. Premiums charged to physicians for direct coverage as a primary classification reflect the total data, including vicarious claims, provided by ISO and these other entities, to which weighted averages are then assigned to come up with rates.

3. Surcharges. . A surcharge is considered a secondary classification. It may be a flat rate or be based upon a percentage of the rate for the primary class. Since no data exist independently to support a surcharge, rates in this

classification can only be based upon guesswork. Furthermore, since the risk of loss which the company purports to insure against by the surcharge is already a component of all risk data upon which the primary classification rate is based, surcharges are inherently duplicative. Physicians pay one premium for all liability, direct or vicarious, and then a second premium for the vicarious component. Such duplication is unnecessary to protect the insurer and would constitute, under most state insurance codes, an excessive and unfairly discriminatory rate.

Intervenors retained the services of J. Robert Hunter as an actuary expert witness for these hearings. Mr. Hunter is the president of the National Insurance Consumers' Organization (NICO) in Alexandria. Mr. Hunter is the former chief actuary and administrator of the Federal Insurance Administration. He has worked with Congress and the Executive Branch in various insurance issues during his career, including the liability insurance crisis of the mid-1970s and, in recent years, repeal of the McCarran-Ferguson antitrust exemption. Mr. Hunter's review of NCRIC's rate filing, together with NCRIC's insistence that the data could not be differentiated, led to our realization of the duplicative nature of these surcharges and other aspects of these practices which are unfair and anticompetitive.

Last year, NCRIC charged my clients $ 305 for each nurse-midwife they employed. It had no data to support that rate, which was based on assumption. This year, with no more data than last year, it made a new assumption that the risk now required a 4400 percent increase. NCRIC would claim justification based on assumption even if it charged twice as much. It has no data to support this extreme change in rate from one year to the next. My clients are hard-pressed to pay this premium, in addition to their own high premiums and those for direct converge for the nurse-midwives. We have learned that other OB/GYNs in this area, upon learning about the 1991 surcharge, ended collaborative relationships with nurse-midwives. All CNMs in the area, as well as the D.C. public health community, are greatly concerned that the chilling effect of this action will prevent OB/GYNs from continuing or entering into collaborative relationships with CNMs, which will consequently diminish nurse-midwives' ability to practice. Since D.C.'s infant mortality rate is the highest in the nation, we cannot as a community afford this loss of access by women to nurse-midwife care. Nearly two hundred people crowded the hearing room last month, nurse-midwives, their clients, and the clients' children, to express their concern about loss of access during this crisis.

This is not only a problem in D.C. Several years ago, the insurance plan controlled by the Illinois State Medical Society (ISMIE) sought to impose a 15 percent surcharge on physicians who worked with nurse-midwives. Following strong opposition by the Illinois Chapter of ACNM and some physicians, which led to the involvement of the state Attorney General's office in a possible antitrust investigation, ISMIE withdrew its proposed rate increase. One of two physician-owned insurance companies in California is currently pressing for a ten percent surcharge, but is opposed by the California Chapter. In 1983, the Federal Trade Commission filed a complaint against the physician-controlled plan in Tennessee, after that plan cancelled the insurance of a physician who consulted with a nurse-midwife group. That complaint resulted in a consent decree. In re State Volunteer Mutual Insurance Company, 102 F.T.C. 1232 (1983). A private antitrust action which resulted from that case is still before the federal courts. Nurse-Midwifery Associates v. Hibbett, 1990-2 Trade Cases (CCH) para. 69,234 (6th Cir. 1990).

During the course of these proceedings in D.C., we have learned that some physician-controlled companies in other states impose surcharges, although so far most do not do so. Direct

coverage for midwives is seldom available from these companies, A chart comparing these companies by state, which was prepared by NCRIC based on a survey it did, is attached to my testimony. It must also be noted that in many states, as in D.C., the medical society insurer has an extremely high market share, some at near-monopoly levels, with the obvious tendency of the monopolist to overcharge. What has become most obvious, however, from these hearings is that, while many of these companies share data and premium information among themselves, none of them has <u>any data whatsoever</u> to support any level of surcharge on physicians who work with nurse-midwives. The unfortunate result of this lack of data is that unfounded assumptions, based upon ignorance, bias, or anticompetitive considerations, are providing the basis for insurance rates that threaten to drive many nurse-midwives out of practice. Underlying the situation is often a history of hostility by the state medical society to expanded practice by CNMs and other advanced registered nurses.

The relief we have requested from the D.C. Superintendent of Insurance is that this rate increase be disallowed because it is unsupported, and that NCRIC be required to gather sufficient data to support any rate increase before such an increase may be resubmitted. We expect a ruling before the end of the year. What, however, can the federal government do to help in this situation, particularly since insurance is regulated by the individual states?

The ACNM and my client believe that one of the most pressing needs at this time is to obtain reliable data in a form which can be used by actuaries. ACNM and ACOG have been collecting claim statistics from their respective memberships for many years, but the physician-owned insurers have refused to consider these. It seems to us that the National Practitioner Data Bank, which was established pursuant to the Health Care Quality Improvement Act of 1986, Title IV of P.L. 99-660, as amended, might provide a partial solution. We understand that, at present, the data collected by the Data Bank do not include the specialty of the practitioner. If that could be specified, and some form of cross-referencing established between health professionals involved in the same case, the first steps toward actuarial data collection would have been taken. These data could, by amendment of the statute, be made available, in summary form without identification of the practitioner, to ISO, PIAA, and other recognized collectors of actuarial data. Within a few years, the beginnings of a realistic data base, which differentiates between direct and vicarious liability, would be available so that insurers and health professionals could determine whether vicarious liability surcharges are necessary and, if so, at what levels those rates should be set. Without such data, nurse-midwives and other non-physicians are at the mercy of supposition and guesswork, disguised as underwriting judgment, which may well destroy their practices. Armed with real data, we have a fighting chance. Ms. Fennell and I would be glad to work with the staff of the Committee in developing appropriate amendatory language to accomplish this result.

PHYSICIAN SURCHARGE
Another Barrier to Practice

As chairperson of the Professional Liability Committee of the American College of Nurse-Midwives, I am contacted regularly by CNMs around the country who are experiencing difficulties related to professional liability insurance. It has become all too apparent that our problems in the area of professional liability insurance coverage are far from over. Although most CNMs have access to coverage, the limits of coverage seem inadequate; and, in almost all cases, the premium is too expensive for the CNMs income level. There has developed over the past two years a growing concern over a new barrier to practice—the liability insurance surcharge.

A surcharge is an additional premium charged by the insurance company to insure the physician who works with a certified nurse-midwife. In some instances, a surcharge is applied for each CNM in the practice; in some cases, there is a limit to the number of CNMs to whom any physician can provide back-up services.

Some insurance companies have also refused physician coverage unless the certified nurse-midwife is a direct employee of the physician. Even in these instances, they have imposed severe restrictions on the CNM's scope of practice and have required direct supervision by the insured physician. These restrictions take the form of a written endorsement attached to the insurance policy which outlines specific conditions that may not be managed by the CNM. I have also received information about situations in two different states where hospitals have been informed by their insurance carriers that a surcharge of 10–25% would be added to the hospital's liability premium should a certified nurse-midwife be granted staff privileges in the institution.

To collect additional data on this situation, the ACNM asked the American College of Obstetricians and Gynecologists to add questions about physician surcharge to their 1988 membership survey. The results of this survey showed that of 2,000 obstetricians/gynecologists surveyed, 127 employ nurse-midwives in their practices. Of these, 60 reported being surcharged and 67 reported no liability insurance surcharge. There was no indication of the amount of surcharge. There also was no data about MD/CNM relationships where the CNM is not employed by the physician.

In February, 1988 the ACNM Board of Directors sent to the membership a survey to gather information about surcharges attached to consultant physician liability insurance policies. By March 30, 1988, 1,229 responses were received. Of these, 899 were from CNMs in clinical practice.

Of these respondents in clinical practice, approximately 10% (91 CNMs) stated that their consulting physicians had been surcharged as a result of working with them; 78 of the 91 reported that their practices had been adversely affected, including 13 whose practices had closed. All regions of the country, but especially Region VI (primarily California) and Region V (primarily Texas) were affected. Significant problems were also reported in Maryland, Florida, Georgia, Mississippi, Minnesota, Montana, and Alaska.

The amount of surcharge ranged from $94 to $23,000 per physician annually. Twenty-five different insurance companies were named, including several state joint underwriting authorities (JUAs) and numerous physician-owned companies. It is interesting to note that the most frequently named carriers who have imposed physician surcharges are physician-owned companies.

Nurse-midwives are not the only group of health care providers to experience the practice of physician surcharges. As early as December, 1986, the *Journal of the American Association of Nurse Anesthetists* reported a similar situation whereby

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surgeons working with nurse anesthetists (CRNAs) were charged higher insurance rates than surgeons working with anesthesiologists. The American Association of Nurse Anesthetists (AANA) was unable to find evidence that physicians working with CRNAs, however, had a higher rate of claims made against their insurance companies than physicians working with anesthesiologists. Furthermore, there was no evidence that physicians working with CRNAs incurred greater expenses per claim than physicians working with anesthesiologists. Because physician-controlled insurance companies were the only companies that imposed such surcharges, the conclusion was drawn that these surcharges were an effort to restrict the practice of CRNAs and to increase the use of anesthesiologists solely for the financial benefit of anesthesiologists.[1]

In combating these surcharges, the AANA has used a variety of techniques, based upon the assumption that the anti-CRNA activity is a result of ignorance rather than malice. The capabilities of nurse anesthestists are described to representatives of the insurance company and copies of relevant studies are provided. The company is challenged to prove from its statistics and experience any justification for the policy.

Attorneys for AANA also have cited a court case which they feel is relevant in this situation. In *American Society of Mechanical Engineers v. Hydrolevel Corporation, 102 S. Ct. 1935 (1982)*, an officer of a competitor caused a professional society to state that a device did not meet the society's standards. The manufacturer of the device sued the professional society for anticompetitive activities, illegal under the antitrust laws. The society claimed it was not liable because the society was not a competitor. The United States Supreme Court ruled that an organization can be held liable for the anticompetitive acts of its agents whenever the agent is acting within the scope of his or her "apparent authority." The AANA counsel holds that insurance companies that are influenced by anesthesiologists to adopt anti-CRNA restrictions or surcharges are similarly allowing themselves to be used by one competitor (anesthesiologists) against another (CRNAs). Although there has been no test case to date, the AANA has found this argument to be a powerful tool in dealing with insurance companies.[2]

In 1986, CNMs in Illinois found their practice threatened when a physician-owned company dropped their liability coverage and imposed a 15% surcharge on their consultant physicians. Certified nurse-midwives and physicians who mobilized against this practice were advised to register a complaint through the Illinois Insurance Commission. The commission, in response, challenged the insurance company to provide actuarial data to show that MDs working with CNMs were at increased liability risk. The antitrust division of the state attorney's office also became involved in the case and the insurance company was eventually directed to drop the surcharge. When no actuarial data could be presented to demonstrate that the surcharge was "fair and just," anticompetitive motives appeared to be influential.

An ongoing case in California involves a group of physicians who have filed a formal complaint with the state insurance commission against the largest physicians' liability insurance carrier in the state. A public hearing has been granted to investigate the complaint of unfair and unnecessary restraints placed on CNMs and the physicians who collaborate with certified nurse-midwives. This case is being supported by ACNM and its members on both the local and national level with planned testimony and physical presence at the proceedings.

The ACNM is committed to developing strategies to combat the use of professional liability insurance surcharges which limit the practice of CNMs and to prevent insurance companies from setting policies which dictate standards for nurse-midwifery practice. We must continue to monitor political and economic issues that may produce barriers to nurse-midwifery practice and work together in acting affirmatively to counteract these forces.

Gail Sinquefield, CNM
Associate Editor

REFERENCES

1. Blumenreich GA, Wolf BL: Restriction on CRNAs imposed by physician-controlled insurance companies. Journal of the American Association of Nurse Anesthetists 54(6):538–539, 1986.

2. Blumenreich GA: Physician-controlled insurance companies. Journal of the American Association of Nurse Anesthetists 56(3):198–200, 1988.

RESULTS OF PHYSICIAN INSURER ASSOCIATION OF AMERICA SURVEY RE: MIDWIFERY

State		Premium For Vicarious Liability (VL)	VL Specifically Excluded From OB" Policy	Other Premiums/Policy Decisions
Alabama				- Currently evaluating - in 1988 on request for VL granted for 25% premimum
Arizona			Yes	VL may be endorsed onto policy if for an individual doctor 5% of midwife direct premimum charged, if for a corporation 10% of midwife direct premium charged.
California	1)	range 10% - 100% of OB Premium		policy excludes deliveries outside JCAHO facility
	2)		Yes	policy excludes deliveries outside JCAHO facility
Connecticut				direct overage for Midwives offerred and required if employed by insured doctor
Florida	1)	5% of OB premium		direct midwife coverage optional with shared limits with doctor in addition to VL premium
	2)			Do not wirte OB or midwives policies

" OB=obstetrician

State	Premium for Vicarious Liability (VL)	VL Specifically Excluded From OB policy	Other Premium/Policy Decisions
3)	No charge if individual OB has midwife and proof of CNM [2] coverage is provided		
Georgia	optional VL but strongly recommended approximately 21% of OB premium	Yes, if VL is not purchased	
Kentucky		Yes	
Louisiana			Less than 10 midwives in state and business decision made not to charge VL premium
Maryland			determined on individual basis
Maine	No charge, if attached CNM to OB's policy with shared limits for premium of 12% of OB's premium		

[2] CNM = Certified Nurse Midwife

State		Premium for Vicarious Liability (VL)	VL Specifically Excluded From OB policy	Other Premium/Policy Decisions
Michigan	1)	200% of Class 1 if another set of limits or 5% of Class 1 if no other limits		
	2)	No charge (excluded OB procedures outside of licensed facilities)		This policy may be changing
Minnesota				CNM added as an additional insured with shared limits for a premium equal to 25% of OB premium
Mississippi		No charge, but due to enact VL premium of 10% of mature OB premium		
Missouri	1)			Screening for CNM's done in underwriting
	2)			None because don't have Ob's supervising CNM's
	3)		Yes	
New Jersey		no charge		

State	Premium for Vicarious Liability (VL)	VL Specifically Excluded From OB policy	Other Premium/Policy Decisions
New Mexico	Small flat rate charged		exclusion for any deliveries outside of hospital
New York		Yes	CNM may obtain direct coverage on a separate policy
North Carolina	10% of direct if OB is employer /supervisor		direct coverage also offerred to CNM's but declined if delivery to take place at location other than hospital
Ohio			limited direct coverage with shared limits for 25% of OB's premium (or 50% of Ob's premium for separate limits)
Oklahoma			midwives not supervised in Oklahoma
Oregon			VL not addressed. If CNM employed by OB then will injure, if nto employed by OB excluded
Pennsylvania	No charge due to cap loss fund and state mandated coverage for CNM's		

State		Premium for Vicarious Liability (VL)	VL Specifically Excluded From OB policy	Other Premium/Policy Decisions
Texas	1)			Do not insure OB's or CNM's
	2)		Yes	
Utah		No charge		if OB wants CNM named as an additional insured, then they share limits for a class I mature premium
Washington		10% of OB premium		
Wisconsin		No charge		Currently reevaluating VL

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PREPARED STATEMENT OF PAMELA GILBERT

Thank you, Mr. Chairman. I am Pamela Gilbert, legislative director of Public Citizen's Congress watch. Public Citizen is a consumer organization founded by Ralph Nader, and Congress watch is the lobbying arm of Public Citizen. Public Citizen has long been active in efforts to reform the nation's health care system and to improve the quality of medical care. I appreciate the opportunity to present our strong view that restricting the rights of victims of medical malpractice will not significantly reduce the costs of health care and will be detrimental to efforts to improve the quality of health care.

INTRODUCTION

Hundreds of thousands of consumers are victimized each year by negligent medical care. Public Citizen estimates that between 150,000 to 300,000 Americans are injured or killed each year by doctor negligence. Yet, most attempts to address the problem of medical malpractice have been embodied in attacks on victims and their right to recover damages from negligent providers, not on solving the problem at the source—ensuring quality care and eliminating medical negligence.

Now President George Bush, Vice President Dan Quayle and the American Medical Association are using the crisis in health care as an excuse to push the same shop-worn proposals to restrict the legal rights of victims. They claim that limiting victims' rights is the solution to the skyrocketing costs of the health care system. Nothing could be further from the truth. In fact, medical malpractice costs make up a minuscule part of overall health care costs. Even if we completely eliminated the right of victims of medical negligence to recover for their losses, we would make barely a dent in the costs of the health care system, if in fact those costs would be reduced at all.

The greatest impact of restricting access to the courts would be felt by the victim of negligent care who might receive little or no compensation. In addition, relieving negligent doctors of responsibility for paying for the costs of their victims' injuries does not mean that these costs would disappear. Someone would have to pay for those injuries, whether it is the victims themselves or public programs like Medicaid. This would not save the country health care costs, it would simply redistribute those costs from the wrongdoers to innocent parties. Finally, reducing victims' rights could even *increase* the costs of the health care system by decreasing the deterrent effects of the system. Reducing deterrence would likely lead to more injuries from malpractice, and hence, higher health care costs.

It is an insult to the tens of millions of uninsured and underinsured Americans to suggest that the solution to the health care crisis is to take away compensation from people who have been injured by careless doctors. This country has the resources to provide adequate health care to all its residents and to adequately compensate the unfortunate victims of medical malpractice. Public Citizen believes that a single-payer health care program similar to the Canadian system could provide universal health care in the U.S. for the same cost as our current inadequate system, without curbing the rights of malpractice victims. The solution to the serious problem of malpractice, on the other hand, is to prevent the injuries in the first place through improved doctor discipline efforts, better training, and the adoption of medical practice guidelines.

THE PROBLEM OF MEDICAL NEGLIGENCE

Medical negligence occurs too frequently

Death and injury due to negligent medical care is a serious problem in this country. According to a 1991 Physician Payment Review Commission report: "the evidence is compelling that rates of inpatient medical injury and negligent medical injury are substantial." [1] Public Citizen estimates that between 150,000 and 300,000 Americans are injured or killed each year by doctor negligence, based on the results of three studies of hospital patients.

The 1991 Harvard Medical Practice study of New York hospitals found that medical negligence caused one percent of hospital patients to suffer an injury which prolonged their hospital stay.[2] Using this figure and extrapolating to all admissions in

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[1] *Physician Payment Review Commission: Annual Report to Congress,* 1991, p. 364.

[2] Brennan, Troyen and others, "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice study I," *New England Journal of Medicine,* February 7, 1991.

New York State in 1984, according to the study, negligence of doctors or hospital staff contributed to approximately 4,000 hospital deaths and an additional 23,000 injuries. Applying these figures nationwide would mean that in 1988, 234,000 injuries and 80,000 deaths were caused by negligence in American hospitals.

Similarly, a study of hospital inpatient records in California found that .8 percent of patients were injured by medical negligence in 1974.[3] Extrapolation of those findings yields an estimate of 249,000 injuries and deaths from negligence in 1988.

In 1976, the Department of Health, Education and welfare's Malpractice Commission estimated that one-half of one percent of all patients entering hospitals are injured there due to negligence.[4] That estimate would indicate 156,000 such injuries and deaths resulted from doctor negligence in 1988.

Furthermore, the RAND Corporation studied records of 182 patients who died in hospitals in 1985.[5] Three independent physicians reviewed the files and found 14-27 percent of the deaths were probably preventable. The study also found evidence that "a small number of factors caused most preventable deaths. In fact, nine reasons encompassed all of the issues identified by the physician panel."

As troubling as these findings are, the studies actually underestimate the rate of medical malpractice. First, the studies do not include death and injury from negligence that occurs outside a hospital setting. Second, the findings include only incidents of negligence that actually result in injury. The studies do not measure the occurrences of substandard care that have the potential to produce injury but fortunately do not result in injury.

The medical malpractice system helps to compensate many victims of malpractice, and to send a message of deterrence to care providers. But clearly, more needs to be done to prevent death and injury from negligent care.

Doctor discipline programs must be improved

Improvements in disciplinary programs against doctors who commit malpractice could prevent a substantial number of incidents of malpractice. This is especially true because, according to a number of studies conducted in the past ten years, a small number of physicians are responsible for most medical malpractice claims. Therefore, by reducing incidents of negligence by those few doctors, most malpractice injury can be avoided.

The following brief review of some of these studies shows the extent to which a small percentage of doctors cause the majority of malpractice injuries:

- In Florida, 3 percent of doctors accounted for 45 percent of the claims paid during the years 1975-1984.[6] Another Florida study found that, between 1975 and 1980, 3 percent of medical specialty physicians accounted for more than 85 percent of that group's payments; 6 percent of obstetrics-anesthesiology physicians accounted for more than 85 percent of that group's payments; and 7.8 percent of the surgical physicians accounted for 75 percent of that group's payments.[7]
- In Los Angeles, 0.6 percent of doctors in a four-year period accounted for 10 percent of all claims and 30 percent of all payments.[8]
- A 1991 study of physicians covered by the primary physician-owned insurer in Tennessee found "a disproportionately small number of doctors are responsible for a disproportionately large frequency and severity of lawsuits." [9]
- In Pennsylvania, one percent of physicians accounted for 25 percent of losses paid over a ten year period.[10]
- A 1987 study of Cook County, Illinois found two percent of all physicians practicing in the county were defendants in 36 percent of all medical negligent litigation filed since 1973.[11]

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[3] Mills, Don, ed., *Report on the Medical Insurance Feasibility Study* (San Francisco: California Medical Association and California Hospital Association, 1977).

[4] *Journal of Legal Medicine,* February, 1976.

[5] Danzon, Patricia, "The Frequency and severity of Medical Malpractice Claims: New Evidence," *Law and Contemporary problems,* 1986.

[6] "Medicine On Trial: The Malpractice Crisis," *Orlando Sentinel,* series beginning April 13, 1986.

[7] Sloan, et al., *Medical Malpractice Experience of Physicians: predictable or Haphazard?,* 262 J.A.M.A., 1989.

[8] Schwartz & Komesar, *Doctors, Damages and Deterrence,* 298 New Eng. J. Med., 1987.

[9] Schmidt, Windsor C., et al., "Factors Associated with Medical Malpractice: Result from a Pilot Study," *The Journal of Contemporary Health Law and Policy,* volume 7, Catholic university of America, 1991.

[10] Hofflander and Nye, "Medical Malpractice Insurance in Pennsylvania," Management Analysis Center, 1985.

[11] Miller, Natalie, et al., "Medical Malpractice: Crisis of Litigation or Crisis of Negligence?" Health Resources Inc., 1987.

• A 1987 Public Citizen study found that "7.5 percent of all practicing physicians in Texas are responsible for 65 percent of the reported claims filed between 1978-1984."[12]

An increase in disciplinary actions against these recidivist doctors would substantially decrease the incidence of malpractice across the country. However, evidence compiled by the Public Citizen Health Research Group shows that, in general, state licensing boards take few disciplinary actions against physicians. According to the report "State Medical Licensing Board Serious Disciplinary Actions in 1989," published by the Health Research Group, in 1989 only 2.64 disciplinary actions (license revocations or suspensions, and probation) were taken per 1,000 physicians nationwide.[13] (I would like to submit this report for the record of today's hearing.)

In contrast, the underwriting practices of physician-owned insurance companies show a significantly higher rate of negligence. For example, in 1985, 6.6 physicians per 1,000 were terminated for negligence-prone behavior and 7 of 1,000 had their practice restricted by physician-owned insurers. This rate is 5 times higher than state disciplinary actions.[14]

In addition to the low numbers of disciplinary actions taken by state licensing boards, the types of actions taken generally do not address the issue of poor quality care due to medical negligence. Instead, most states focus attention on physicians with drug and alcohol problems, occurrences that are easier to define and identify than incidents of negligence conduct. The fact that most states fail to exert the maximum possible effort to discipline negligent doctors is one of the most serious threats to the health of American patients, and a major reason why the legal system is so important as an adjunct to state regulatory actions.

RESTRICTING VICTIMS' IS NOT THE ANSWER TO THE HEALTH CARE CRISIS

Limiting legal rights will not lower health care costs

The U.S. health care system is failing fast. The Department of Health and Human Services recently reported that U.S. spending on health care rose to $666.2 billion in 1990. This represents over 12 percent of the gross national product, up from 11.6 percent in 1989. Despite these massive expenditures, the U.S. ranks 12th worldwide in life expectancy; 21st in the number of deaths of children under age 5; and 22nd in infant mortality. Furthermore, approximately 37 million Americans have no health insurance at all, and another 50 million are underinsured.

In order to avert disaster, this nation must reduce health care costs. Studies by the U.S. General Accounting Office, Physicians for a National Health Program, and Public Citizen show a potential savings in administrative costs between $60 and $135 billion if the U.S. adopts a single-payer health care plan similar to the system in Canada. By redirecting this wasteful administrative spending to health care, the U.S. could provide universal coverage for all Americans without spending more money on health care than we do today.

Rather than endorse this sensible and humane program, President Bush, Vice President Quayle and the American Medical Association claim that placing restrictions on victims' rights will lower costs and increase access to health care. Even if this were true, it would be unfair and cruel to cure the problems in the health care system on the backs of injured victims. In fact, however, limiting legal rights will not result in a cost savings in the health care system.

Medical malpractice costs are a minuscule fraction of overall health care costs. In 1989, the annual cost of health care exceeded $600 billion.[15] Malpractice premiums earned by insurers that year totaled $5.1 billion [16]—less than one percent of total health care costs in the U.S. Contrast this with the administrative costs of the system, which are estimated to range from 10 percent to 25 percent of health care costs.

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[12] "Medical Malpractice in Texas: Are We Covering Up the Symptoms Instead of Curing the Disease?" Public Citizen, compiled from reports by the Texas State Board of Medical Examiners, 1987.

[13] VanTuinen, Ingrid and Wolfe, Sidney M., "State Medical Licensing Board Serious Disciplinary Actions in 1989 (Latest Data Available)," Public Citizen Health Research Group, February, 1991.

[14] Schwartz, William B. and Mendelson, Daniel N., "The Role of Physician-owned Insurance Companies in the Detection and Deterrence of Negligence," *Journal of the American Medical Association*, 1989, vol. 260, no. 10, pp. 1342-1346.

[15] *Financing Review*, U.S. Health Care Financing Administration, U.S. Department of Health and Human Services, volume 12, No.2, Winter, 1990.

[16] *1989 Profitability Study* (By Line By State), National Association of Insurance Commissioners, 1990.

Malpractice premiums also make up only a small part of most doctors' expenses. According to American Medical Association figures, in 1989, professional liability insurance premiums accounted for only 4.9 of revenues for the typical physician practice.[17] The largest expense was for nonphysician employee wages. That same year, the nation's largest medical malpractice insurer lowered its rates in 34 states.[18] And while insurance rates decreased in 1989, the average income of physicians increased by almost 8 percent that year, far more than the 4.6 percent rate of inflation. The increase brought doctors' incomes to $155,000, an increase of $11,100 over 1988.[19] The high cost of health care cannot be blamed on the small costs of protecting victims from negligent physicians.

Injured victims rarely bring lawsuits.

It is not surprising that malpractice costs make up a small portion of health care costs, since on the whole Americans rarely use the courts for accident compensation. According to a 1991 RAND study, only 3 percent of seriously injured victims involved in accidents not related to the workplace or automobiles file a liability claim.[20] An earlier Rand study concluded, "At most, one in ten incidents of medical malpractice results in a claim, and of these, less than half, or one in 25 receive payment." [21] similarly, the 1991 Harvard Medical Practice study estimated that in 1984, less than two percent of negligently injured patients filed a claim to recover damages.[22] The study further found that 16 times as many patients suffered an injury from medical negligence as there were patients who received compensation from the medical malpractice system. In fact, a 1991 study by a committee within the American Law Institute states: "Deserving victims with legitimate claims continue to face high barriers to obtaining tort redress." [23] In short, few victims of malpractice ever bring a liability claim, and even fewer receive compensation through the legal system. If any changes are made to the malpractice system, therefore, the modifications should seek to open up the system to more claims, not to make it even more difficult to bring successful lawsuits.

Jury awards are not excessive.

Supporters of placing caps on damage awards and other limits on the malpractice system often claim that these reforms are necessary because jury awards in malpractice cases are excessive The evidence shows otherwise. A U.S. General Accounting Office study found that the median malpractice payment in 1984 was $18,000, and that 69 percent of victims received less than $50,000.[24] Furthermore, the study found that any increases in settlements could be attributed to the rise in health care costs. According to the report, between 1981-1984, the average malpractice verdict increased at an annual rate of 3.9 percent, yet health care costs increased 11.8 percent.

In summary, malpractice insurance premiums represent less than one percent of the nation's health care bill. Fewer than ten percent of malpractice victims ever even bring a liability claim to recover their losses, and only a fraction of these claims are successful. Furthermore, jury awards and settlements in malpractice cases are not excessive, nor are they increasing at a high rate. Finally, it has been estimated that the malpractice system helps reduce malpractice costs by about 10 percent because of the incentives in the system that prevent malpractice from occurring.[25] Therefore, restricting the medical malpractice system could increase

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[17] Gonzalez, Martin L., *Socioeconomic Characteristics of Medical Practice 1990/1991,* American Medical Association, p.22.

[18] "Biggest Malpractice Insurer Cuts Rates in 34 States," *Liability Week,* Volume 4, No. 16, April 17, 1989.

[19] "Doctors' Average Income Reaches $155,000," *Federal and State Insurance Week,* December 14, 1990.

[20] Hensler, Deborah R., et al., *Compensation for Accidental Injuries in the United States,* Rand Corporation, Institute for Civil Justice, 1991.

[21] *Economic Analysis of the Medical Malpractice System,* the Rand Corporation, 1983.

[22] Brennan, Troyen, et al., "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I," *New England Journal of Medicine* 324:370-6, 1991.

[23] "Reporters' Study on Enterprise Responsibility for Personal Injury," *Approaches to Legal and Institutional Change, Volume II,* The American Law Institute, 1991 (". . . the views in the Reporters' study have not been considered by the membership and do not represent the position of the Institute . . .").

[24] U.S. General Accounting Office, *Medical Malpractice: Characteristics of Claims Closed in 1984,* April, 1989.

[25] Hofflander, Alfred E. and Nye, Blaine R., "Medical Malpractice in Pennsylvania," Management Analysis Center, Inc., 1985, p. xxiii.

overall costs by reducing these incentives and increasing the incidence of malpractice. And it must be remembered that placing limits on victims' rights to recover from negligent doctors will not eliminate those costs. Restricting victims' legal rights will merely redistribute the costs of malpractice to innocent parties.

DEFENSIVE MEDICINE

What's the problem? What's the solution?

Advocates of limiting victims' rights to sue argue that it is not just insurance premiums that make the medical malpractice system expensive. They claim that "defensive medicine"—medical practices that are not in the best interest of the patient, but are performed to avoid liability—is driving up health care costs. But so far, no one has been able to adequately measure the amount of "defensive medicine" that exists, nor to precisely identify its cause. The American Medical Association estimates that "defensive medicine" cost $20 billion in 1988. The Physician Payment Review Commission has refuted this and other figures, however, saying, "Studies that use physicians' estimates of the amount of defensive medicine they practice are not sufficiently reliable to make quantitative estimates." [26]

One reason it is so difficult to quantify the costs of "defensive medicine" is that there is no single definition of the term. Depending on the definition, "defensive medicine" may actually be better medicine. Measures that physicians take in response to the threat of malpractice include: telling patients more about risks, keeping better patient records, obtaining more consultations, taking better initial histories from patients, scheduling more followup visits, providing more preventive services, studying the professional literature more regularly, attending more continuing medical education courses and improving communication with their patients.[27] Certainly these practices could improve the quality of care and thereby reduce negligence and injury. And preventing costly injuries saves the health care system money.

Determining the cause of "defensive medicine" has proved equally elusive. We have found no empirical evidence that the liability system is responsible for a substantial amount of costly or unnecessary medical practices. Two studies have recently been published indicating that these kinds of practices are caused by a very different motivation—the profit motive.

A new study by the state of Florida found that physicians in that state own the vast majority of certain health care facilities, and that these ownership arrangements have led doctors to order unnecessary tests and questionable treatments in order to increase their profits.[28] The report, commissioned by the Florida Health Care Cost Containment Board, found that at least 40 percent of the practicing doctors in the state have invested in facilities to which they can refer patients. In the case of diagnostic-imaging centers, the study found that doctors own 93 percent of such facilities. In addition, the study reported that the number of tests per patient is almost twice as great in doctor-owned labs than in those not owned by doctors. Likewise, the average per patient charge in a joint venture facility was more than twice the charge in a non-joint venture lab.

The Consumer Federation of America reported similar findings in their study of doctor ownership of diagnostic testing facilities. The report concluded, "The rapid spread of physician ownership of diagnostic testing facilities is a much more likely cause of rising diagnostic costs than defensive medicine.[29] The report found that physicians own or have compensation arrangements with one-third to one-half of all clinical laboratories. In the field of Magnetic Imaging Centers, physician ownership was found to exceed 50 percent. The study also reported:

- Compared to tests ordered at independent labs, self-dealing physicians ordered 34 to 96 percent more tests;
- Prices are 2 to 38 percent higher at physician-owned labs than independent labs;
- The total bill was 25 to 125 percent higher for physician- owned labs.

Before victims are forced to give up their legal rights in the name of reducing so-called "defensive medicine," the economic incentives inherent in joint venture medi-

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[26] Physician Payment Review Commission, Annual Report to Congress, 1991.
[27] Physician Payment Review Commission, Annual Report to Congress, 1991.
[28] Suplee, Curt, "Florida Reviews Ownership of Clinics," *The Washington Post,* August 9, 1991.
[29] Cooper, Mark N., "Physician Self-Dealing for Diagnostic Tests in the 1980s: Defensive Medicine vs. Offensive Profits," Consumer Federation of America, October, 1991.

cal facilities owned by doctors must be reduced or eliminated. Until the profit motive is removed from such medical practices, controlling the prevalence of unnecessary and expensive medical procedures will be impossible.

DON'T LIMIT VICTIMS RIGHTS, LIMIT NEGLIGENCE

Far too many innocent people are injured or killed every year due to medical malpractice. The liability system is designed to compensate the victims of medical negligence and to deter physicians from negligent behavior. The malpractice system is not perfect—too few victims are able to recover through the courts and the incidence of malpractice continues at an unacceptably high rate. Therefore, attempts to lower the cost of health care by limiting victims rights in medical malpractice would be both misguided and cruel. The Physician Payment Review Commission concluded in its 1991 report to Congress that:

> " . . . tort reforms tried to date are unlikely to improve significantly the malpractice system's performance . . . . Tort reform is generally geared toward excluding claims rather than including in the system the many negligent injuries that presently do not result in claims. Neither deterrence nor defensive medicine is likely to be much affected by tort reform." [30]

The only humane and effective mechanism for lowering medical malpractice costs is to limit the incidence of physician negligence and thereby lower the number of malpractice victims.

RECOMMENDATIONS

Rather than limit victims' rights, Public Citizen urges that the following reforms be implemented on the state and national levels to reduce medical malpractice and improve the quality of health care in this country:

1. Better doctor discipline is essential to reducing the incidence of medical negligence. Because a small number of doctors cause the most malpractice, removing incompetent providers from practice will lower needless injuries and deaths resulting from negligent care.

- States should give licensing boards more power to discipline physicians, including emergency suspensions pending formal hearings in cases where a doctor poses a potential danger. In addition, medical board decisions should take effect while being appealed through the court system.
- State boards should be restructured to ensure strong consumer representation and loosen ties with medical societies.
- Adequate resources should be provided to the boards to ensure timely and thorough investigations of complaints. Congress should create a small program of grants-in-aid to state medical boards. The grants should be tied to the boards' agreements to meet certain performance standards.
- Consumers must have increased access to information on physicians' medical malpractice history. The National practitioner Data Bank that holds information about actions taken against negligent doctors should be open to the public. In addition, the Drug Enforcement Agency should release a monthly list of all practitioners whose controlled substances prescription licenses have been suspended.
- Insurance companies should forward all claiming and settlement information on physicians to state licensing boards.

2. Insurance reform would ensure sensible underwriting and thereby lower costs in the health care system.

- Insurance companies should be required to better spread risk by placing all physicians in a unified pool. Currently, the sub-categories used by insurance companies result in sky-high premiums for certain specialties.
- In order to differentiate "high-risk" doctors, insurance companies should charge rates based on a physician's experience. This would ensure that doctors with histories of negligent behavior would pay more.

3. Improved physician training and oversight would limit negligent behaviour, and the resulting costly injuries.

- Risk management programs should be implemented to decrease medical negligence.

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[30] *Physician Payment Review Commission: Annual Report to Congress,* 1991, p.382.

• Physician recertification should be implemented, requiring written examinations, and audits of medical performance through a review of patient records.

• Practice guidelines should be developed for certain procedures. A 1989 Harvard Medical School study found that practice guidelines for anesthesia have drastically reduced the incidence of death or brain damage to patients. The study also found a dramatic drop in the cost of medical malpractice premiums for anesthesiologists.

• Physicians who are aware of other doctors' incompetence should be encouraged through confidentiality and immunity to report negligence to the appropriate disciplinary body.

Finally, the U.S. should adopt a single-payer national health program modeled on the Canadian system. This sensible step could provide our country's residents with universal and adequate health care at the same cost as the current system, which has failed a large segment of society. A universal health program would also have the effect of reducing the numbers of malpractice lawsuits, because injured victims would not need to turn to the legal system to be compensated for their health care expenses. Those expenses would simply be paid for through the public plan.

We look forward to working with the Congress to adopt a national health program, and to institute reforms that would reduce the incidence of medical malpractice and improve the overall quality of health care. We will work strenuously to defeat, however, any measures that would make it even more difficult for victims of medical malpractice to recover from the wrongdoers. Thank you.

Attachment.

STATE MEDICAL LICENSING BOARD SERIOUS DISCIPLINARY ACTIONS IN 1989 (Latest Data Available)

February, 1991
Ingrid VanTuinen
Sidney M. Wolfe, M.D.

PUBLIC CITIZEN HEALTH RESEARCH GROUP REPORT: STATE MEDICAL BOARD DOCTOR DISCIPLINARY ACTIONS 1989 RANKING OF STATES

We have just analyzed the Federation of State Medical Boards' December 1990 report regarding doctor disciplinary rates for 1989, the most recent year available. According to our analysis, 1989 is the first year in which the overall rate of serious disciplinary actions per 1,000 M.D.s actually declined, from 2.77 serious actions per 1,000 M.D.s in 1988 to 2.64 such actions in 1989. The overall number of serious disciplinary actions (medical license revocations, suspensions, and probations) increased 1.34%, from 1,489 in 1988 to 1,509 in 1989[1]. This slight increase in the total number of serious disciplinary actions comes after a year of no increase (see Table 1, p.2, and Figure 1 on the following page), as the number of serious disciplinary actions taken in 1988 exactly matched the number taken in 1987.[2] In 1989 21 states increased their serious disciplinary action rate, 24 decreased that rate, and 6 states maintained the same rate.

In June, 1990, Public Citizen Health Research Group Published 6,892 Questionable Doctors Disciplined by States or the Federal Government. However, the newly-received 1989 data was not available at that time (the 1988 data became available in July of 1990). In that book we noted that state medical boards had increased the number of serious disciplinary actions they levied against physicians in 1987, the fourth year of increase in a row, but, based on data from many states, predicted no significant increase in this rate between 1987 and 1989.[3] Indeed, there was no increase from 1987 to 1988, and despite a slight increase from 1988 to 1989, Public Citizen believes that the 1989 disciplinary rates still aren't high enough to accurately reflect the frequency of behavior warranting disciplinary action. For example, under current disciplinary standards, a physician who operates drunk, commits a gross act of negligence, or sexually assaults a patient might receive a mere slap on the wrist from many state medical boards, and might never even be brought to the attention of such boards in other states.

We have previously estimated that well over 100,000 Americans are injured or killed in hospitals each year as a result of doctors' negligence. The fact that most states fail to exert the maximum possible effort to discipline these doctors is one of the most serious threats to the health of American patients.

The public would be much better protected if every state would discipline as many doctors as Missouri, the top state in our rankings for 1989. Missouri had a disciplinary rate of 7.02 serious actions per 1,000 physicians, over 14 times more than Connecticut, which took only 0.48 such actions per 1,000 physicians. If all states had a rate of serious disciplinary action equalling Missouri's, 4,005 doctors would have been

sanctioned in 1989, over 2.6 times more than the 1,509 actions actually taken in 1989. This would mean that an additional 2,496 American physicians would have been subjected to serious disciplinary measures, significantly increasing the amount of patient protection against incompetent or otherwise poorly-practicing physicians.

OVERALL U.S. TRENDS

For the sixth time in the last seven years, Public Citizen Health Research Group has analyzed the most recent (1989) data which state medical licensing boards give to their national organization, the Federation of State Medical Boards. The three types of serious disciplinary actions that we use as the basis for ranking the states are 1) revocation of license, 2) suspension of license, and 3) probation. A fourth disciplinary category, which includes reprimands, voluntary surrender of license and a variety of other actions, was excluded from our analysis because the Federation does not release details as to what proportion of these actions substantially affect a physician's license and what proportion do not.

As can be seen in Table 1 below, in 1989 state licensing boards took 1,509 serious disciplinary actions against U.S. physicians. While the number of actions taken by such boards doubled from 1984 (745) through 1987 (1489), 1988 was the first year in which the number of actions did not rise from the previous year. From 1984 to 1985, the number of actions taken jumped by 344, an increase of 46%. The periods between 1985 and 1986, and between 1986 and 1987, each saw a 17% increase in the rate of discipline. This upward trend came to a complete stop in 1988. And though 1989 did see a slight but insignificant increase in the number of serious disciplinary actions taken, it is the second year in a row that the number of such actions has remained essentially the same. It is also the first year that the actual nationwide rate has decreased (from 2.77 serious actions for every 1,000 doctors to a rate of 2.64), despite the fact that the actual number of non-federal doctors has increased 6% (from 538,008 to 570,579[4] doctors).

TABLE 1
SERIOUS DISCIPLINARY ACTIONS AGAINST U.S. PHYSICIANS (M.D.s)
1984-1989

YEAR	1984	1985	1986	1987	1988	1989
NUMBER OF ACTIONS	745	1089	1277	1489	1489	1509
CHANGE FROM PREVIOUS YEAR	--	+344	+188	+212	+0	+20
PERCENT	--	+46%	+17%	+17%	+0%	+1.3%

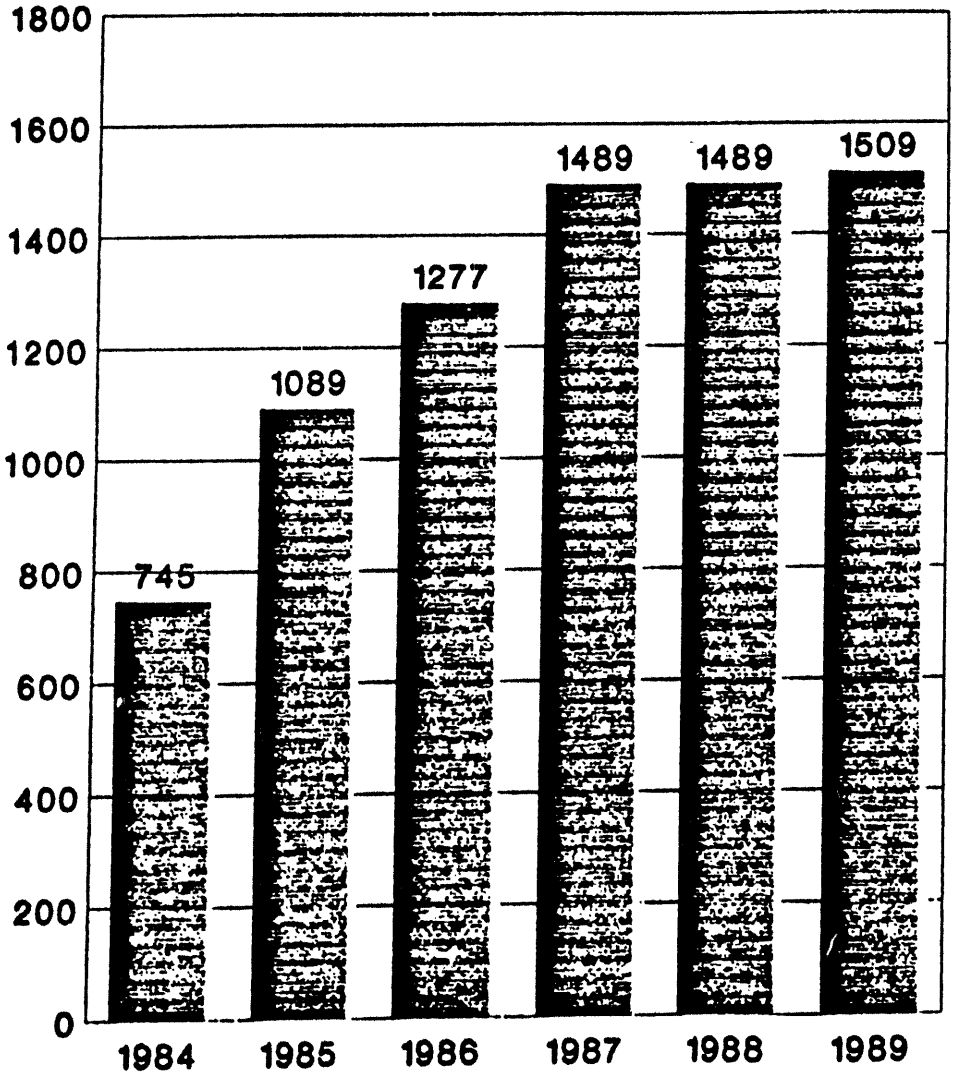
STATE BY STATE RANKING

The number and rate per 1,000 M.D.'s of serious disciplinary actions for each state and the District of Columbia in 1989, compared to 1988, can be seen in Table 2 on the following page. These rates are calculated by dividing the number of serious disciplinary actions (reported by each state to the Federation of State Medical Boards) by the number of non-Federal M.D.'s in each state.

Better News

Seven of the top 10 states in 1988 remained in the top 10 in 1989. These include **Georgia, Iowa, Oklahoma, Mississippi, West Virginia, Missouri, and Colorado.**

SERIOUS DISCIPLINARY ACTIONS* 1984 THROUGH 1989



*Physician license revocations, suspensions, and probations.

TABLE 2

SERIOUS DISCIPLINARY ACTIONS (REVOCATIONS, SUSPENSIONS, AND PROBATIONS) BY STATE MEDICAL LICENSING BOARDS AGAINST MDs IN 1988 AND 1989

RANK 1989	RANK 1988	STATE	# ACTIONS 1989	# ACTIONS 1988	SERIOUS ACTIONS PER 1000 MDs	# OF DOCTORS
1	3	MISSOURI	74	79	7.02	10,536
2	1	GEORGIA	78	90	6.80	11,467
3	6	MISSISSIPPI	24	24	6.63	3,621
4	4	OKLAHOMA	31	38	6.12	5,063
5	8	WEST VIRGINIA	20	19	5.89	3,394
6	2	IOWA	25	37	5.43	4,604
7	15	ALASKA	4	3	5.30	755
8	7	COLORADO	37	42	4.98	7,434
9	20	SOUTH CAROLINA	29	18	4.87	5,951
10	17	INDIANA	45	34	4.84	9,291
11	25	LOUISIANA	39	21	4.49	8,688
12	12	MINNESOTA	44	43	4.33	10,165
13	13	KENTUCKY	28	27	4.27	6,555
14	11	ILLINOIS	112	126	4.25	26,349
15	26	ARKANSAS	15	9	3.91	3,834
16	40	NEBRASKA	11	4	3.79	2,902
17	33	TENNESSEE	35	20	3.50	9,987
18	22	OHIO	77	68	3.39	22,706
19	14	FLORIDA	94	116	3.09	30,377
20	19	NEW MEXICO	9	9	3.01	2,987
21	50	RHODE ISLAND	8	1	2.98	2,685
22	51	MONTANA	4	0	2.83	1,411
23	31	NORTH CAROLINA	36	26	2.78	12,928
24	41	WYOMING	2	1	2.71	738
25	30	OREGON	17	13	2.70	6,296
26	16	NEW JERSEY	51	74	2.54	20,045
27	21	UTAH	8	10	2.43	3,294
28	28	ALABAMA	16	15	2.35	6,812
29	9	HAWAII	6	13	2.23	2,691
30	5	NEVADA	4	12	2.20	1,819
31	35	NEW YORK	130	98	2.17	59,906
32	48	DELAWARE	3	1	2.16	1,392
33	49	ARIZONA	17	4	2.13	7,975
34	44	CALIFORNIA	141	93	1.85	76,272
35	10	SOUTH DAKOTA	2	5	1.84	1,089
36	29	MICHIGAN	33	40	1.81	18,229
37	34	D.C.	7	8	1.80	3,885
38	38	PENNSYLVANIA	51	43	1.69	30,093
39	27	MASSACHUSETTS	33	47	1.57	20,958
40	47	WISCONSIN	15	8	1.53	9,784
41	24	KANSAS	7	12	1.48	4,745
42	39	IDAHO	2	2	1.45	1,384
43	23	VIRGINIA	18	36	1.35	13,299
44	43	VERMONT	2	2	1.26	1,587
45	32	MAINE	3	5	1.21	2,485
46	46	WASHINGTON	11	11	1.01	10,886
47	36	MARYLAND	16	25	0.98	16,268
48	45	TEXAS	29	35	0.94	30,900
49	18	NORTH DAKOTA	1	4	0.84	1,190
50	37	CONNECTICUT	5	15	0.48	10,474
51	42	NEW HAMPSHIRE	0	3	0.00	2,393
TOTALS			1,509	1,489		570,579

A similar study conducted in California in 1974 found that 0.8 percent of hospital patients had either been injured by negligence in the hospital or had been hospitalized because of negligent care.[6] Extrapolation of those findings yields an estimate of 249,000 injuries and deaths from negligence in 1988.

In 1976 the HEW Malpractice Commission estimated that one-half of one percent of all patients entering hospitals are injured there due to negligence.[7] That estimate would indicate 156,000 such injuries and deaths resulted from doctor negligence in 1988.

Since there is no evidence that doctors in any one state are generally more or less competent than in another, differences in the rate of doctor discipline reflect differences in how serious states are about disciplining doctors. The disparity between states with higher rates of doctor discipline and states with only a fraction of those rates is cause for alarm by the residents of the low-discipline states. People in these states are much more likely than people in high-discipline states to be injured or killed by doctors still on the loose because they haven't been "caught". What would be unacceptable medical practice in one state may go unnoticed by the state licensing board in another state.

Even though the 1989 total of 1,509 serious doctor disciplinary actions demonstrates a slight increase over the 1987/1988 total, it falls very short of catching most of the incompetent doctors in this country. Most states base more disciplinary actions on doctors' drug and alcohol problems (9.2%) than on medical negligence or incompetence (8.9%).[8] Boards say proving incompetence is difficult, and investigations of substandard care soak up resources like a sponge. Instead, they use prescription violations and fraud convictions, offenses that are easier to document because they leave a paper trail, as potential indicators of more serious violations. While this may catch those doctors whose ability to practice medicine has been impaired by chemical dependency, it does not adequately address the issues of quality of care that are not related to such a dependency.

A further indication that the rate of doctor discipline by most state medical boards is too low comes from a 1989 Tufts University study.[9] Those researchers found that physician-owned insurance companies terminated coverage of 6.6 out of every 1,000 policyholders in 1985 because of negligence-prone behavior. In addition, they restricted the practice or imposed other medical sanctions on an additional 7 of every 1,000 policyholders, whose performance was viewed as substandard. Thus, if the combined rates of malpractice insurance termination and other sanctions by physician-owned insurance companies (13.6 per 1,000 physicians) were applied to all physicians in the U.S., this rate would be more than 5 times higher than the actual 1989 average rate of serious disciplinary actions by state licensing boards and would affect a total of 7,760 physicians.

DOCTOR DISCIPLINE AND MEDICAL MALPRACTICE

Until the rate of doctor discipline in this country significantly increases, there is no realistic possibility of a major decrease in the amount of medical malpractice or medical malpractice litigation. At the heart of the so-called medical malpractice litigation crisis, other than the manipulative efforts of the insurance industry, is actual malpractice, that is, patients being injured or killed by negligent physician behavior.

States demonstrating significant increases in serious disciplinary rates include **South Carolina** (up from 20th to 9th), **Louisiana** (up from 25th to 11th), **Nebraska** (up from 40th to 16th), **Tennessee** (up from 33rd to 17th), **Montana** (up from 51st to 22nd and showing the largest single increase), **Wyoming** (up from 41st to 24th), **Delaware** (up from 48th to 32nd), and **Arizona** (up from 49th to 33rd).

In our last report we noted that California and New York, two of the states that take high numbers of serious disciplinary actions, had both declined in our ranking. This was especially alarming in the case of New York, which took fewer than half the actions in 1988 (98) as it had in 1987 (259). Fortunately, both states increased the number of serious disciplinary actions they took in 1989. However, even though California rose from 93 actions (44th) to 141 (34th) and New York rose from 98 actions (35th) to 130 (31st), both were still well under one third the rate of serious disciplinary actions taken by Missouri.

It should also be noted that **Georgia**, **Iowa**, and **Oklahoma** have been in the top 10 states for doctor disciplinary rates for five years in a row, and **West Virginia** has been in the top 10 for four consecutive years. While the number of serious disciplinary actions taken by a state may fluctuate from year to year for a number of reasons, the fact that these states have consistently ranked at or near the top of the list suggests a consistent effort to improve the quality of health care available in these states.

Worse News

At the other end of the scale, 14 of the bottom 20 states for doctor disciplinary rates in 1988 remained there in 1989. Of these 14 states, 4 showed increases in disciplinary rates (**Delaware**, **Arizona**, **California**, and **Wisconsin**), 2 maintained a steady rate (**Pennsylvania**, and **Washington**), and 8 actually declined (**the District of Columbia**, **Idaho**, **New Hampshire**, **Vermont**, **Maine**, **Maryland**, **Texas**, and **Connecticut**).

Two other states, in the bottom 20 for the first time, showed enormous declines in their disciplinary rates. **North Dakota** fell from 18th to 49th, a drop of 31 places. And **South Dakota** fell 25 places, plummeting out of the top 10 from 10th to 35th. Unfortunately, two other states dropped out of the top 10 as well: **Hawaii** fell 20 places, from 9th to 29th; and **Nevada** fell 25 places, from 5th to 30th.

Other declines were seen for **Massachusetts** (which fell from 27th to 39th) and **Kansas** (which fell from 24th to 41st). **New Hampshire** retains the distinction of having the worst disciplinary rate for 1989, with no serious disciplinary actions taken in that year.

IMPLICATIONS OF LOW RATES OF DOCTOR DISCIPLINE

The implications for all states, especially those with low doctor disciplinary rates, are quite serious. Public Citizen estimates that at least 100,000 Americans are injured or killed each year by doctor negligence, based on the results of three studies.

In the first, Harvard researchers recently found that 1 percent of a representative sample of patients treated in New York state hospitals in 1984 were injured, and one quarter of those died, because of medical negligence.[5] Nationwide, that translates into 234,000 injuries and 80,000 deaths in 1988 from negligence in American hospitals.

WHY WAS MISSOURI NUMBER ONE IN DOCTOR DISCIPLINARY ACTIONS IN 1989?

The Missouri State Board of Registration for the Healing Arts is one of the best medical disciplinary boards in the country. The board has proven its excellence by achieving the highest disciplinary rate on our 1989 list, and by steadily rising in our rankings from 11th in 1987 to 3rd in 1988 to its present position.

As we noted in our report 6,892 Questionable Doctors Disciplined by States or the Federal Government, Missouri has had a strong medical disciplinary board for the past several years, and amendments to the state's Medical Practice Act, passed in 1987, have only made it stronger. It is one of the few boards that does not wait for formal complaints against doctors before initiating investigations; it seeks out errant physicians on its own. (Georgia, Mississippi, Oregon, Utah, Virginia, and West Virginia also proactively seek out poorly practicing physicians.)

Interestingly, it was only in 1987 that any of the Missouri board's actions became public. However, the board may still enter into confidential disciplinary consent orders with any physician it chooses, which may not always be in the best interests of consumers. Furthermore, the state is also prohibited from publishing the names of physicians who voluntarily enter substance abuse treatment programs and have been placed on probation by the board. Missouri's rate of confidential disciplinary actions may in fact have boosted its 1989 serious disciplinary action rate even higher.

RECOMMENDATIONS FOR THE FEDERAL GOVERNMENT

1. **Create grants and standards.** Congress should create a small program of grants-in-aid to state medical boards. The grants should be tied to the boards' agreements to meet certain performance standards, which should be developed by the Public Health Service, as the Department of Health and Human Services Office of Inspector General recommended in 1990.[10]

In developing these standards the Public Health Service should work with the Federation of State Medical Boards' Assessment Task Force. In September, 1990 the FSMB received a federal contract for $200,000 to undertake the development of a self-assessment instrument for state medical boards. The goal of the task force is to produce a sound and objective means by which the boards can assess their performance over time and in comparison with other boards.

The standards should include (but not be limited to) the following: processing complaints within a certain limited period of time; maintaining a certain level of staffing and having staff meet certain qualifications; disseminating disciplinary information to the public; and other standards.

2. **The Medicare Peer Review Organizations**, which have been practically moribund in disciplining physicians for substandard care, should become more aggressive. The PROs should hire investigators and advisers trained in law enforcement, so that fewer of their sanctions will be overturned.

As a 1990 Institute of Medicine report noted, the PROs are not evaluated on their ability to detect and correct poor quality care.[11] The Department of Health and Human Services should change its evaluation procedures to place more emphasis on quality.

3. **Open the National Practitioner Data Bank.** In 1986 Congress passed the Health Care Quality Improvement Act. This act mandated the establishment of a data bank containing information on adverse professional review actions taken against doctors, and on doctors who had been sued for malpractice and on whose behalf settlement or adjudicated payments had been made. Unfortunately, the law establishing the data bank also required that it be closed to the general public. Congress should pass legislation opening the data bank to the public.

4. **The Drug Enforcement Administration** should release a monthly list of all practitioners whose controlled substance prescription licenses have been revoked, restricted, or denied. The list should be widely distributed to pharmacies, state pharmacy and medical boards, and the general public.

Far too many doctors continue to prescribe controlled substances after their DEA licenses have expired or have been revoked. The DEA should consider requiring pharmacies to subscribe to an on-line service with which they could check the validity of these DEA license numbers.

5. **Require doctor recertification.** Congress should consider legislation proposed by Rep. Pete Stark, D-Calif., to require physicians who accept Medicare patients to be periodically recertified for competency.

RECOMMENDATIONS FOR STATES

1. **Strengthen the statutes.** States that have not already done so should adopt a version of the Model Medical Practice Act developed by the Federation of State Medical Boards[12], or, preferably, stronger laws.

2. **Restructure the Boards.** States should sever any remaining formal links between state licensing boards and state medical societies. Members of medical boards (and separate disciplinary boards, where present) should be appointed by the governor, and the governor's choice of appointees should not be limited to a medical society's nominees.

At least 30 percent of the members of each state medical board and disciplinary board should be public members who have no ties to health care providers.

The governor should appoint members to the Medical Board whose top priority is protecting the public's health, not providing assistance to physicians.

3. **Inform the public.** Each state's Open Records Law and its Medical Practice Act should state that all formal disciplinary actions against licensed professionals are fully public records.

Each legislature should require widespread dissemination of final disciplinary orders. Lists of those disciplined and full disciplinary orders should be promptly available to all requesting them by mail.

Notices of disciplinary actions should be sent to the local news media and to all hospitals, HMOs, and other health care providers in the state, as well as to other state agencies, the federal Department of Health and Human Services, and the federal Drug Enforcement Administration. Federal law already requires that such information be reported to the National Practitioner Data Bank, which began operating on September 1, 1990.

4. **Strengthen board authority.** Every medical board should have the authority to impose emergency suspensions pending formal hearing in cases where there is a potential danger to the public

health. Boards should aggressively use this authority when they learn of a potentially dangerous doctor.

Medical boards should have the authority to accept the findings of other state boards and of the federal Department of Health and Human Services and the Drug Enforcement Administration. If a physician has been disciplined by another state, the second state's medical board should be required to impose sanctions at least as stringent as those imposed by the first state.

Each state should require physicians who have been licensed in other states and who seek licensure in a new state to submit affidavits that they are not under investigation elsewhere before being granted a new license. Physicians who are under investigation should not be permitted to practice until the board has heard the details of their case and can evaluate their competency.

Each legislature should provide its state medical licensing board with authority to examine physicians for physical, mental and professional competence and to test them for alcohol and drug use upon reason to believe that a problem exists in one of these areas.

5. **Encourage complaints.** Each legislature should provide for the protection of confidentiality and immunity to those who report violations of the Medical Practice Act to the Board. Such protections should also be extended to board members, their staff and consultants.

Each legislature should require all licensed health care practitioners to report Medical Practice Act violations by other practitioners to the medical board, with large civil penalties for failure to do so. Boards should aggressively use their authority to enforce the requirement that all health care providers report such violations. Each legislature should also require hospitals to report all revocations, restrictions, or voluntary surrenders of privileges.

Courts should be required to report all indictments and convictions of physicians to the medical disciplinary board. In addition, each legislature should require liability insurers to report all claims, payments, and policy cancellations to state medical disciplinary boards. It should request reports from other state agencies, Medicare, the DEA and other federal agencies. It should also require impaired physicians' programs to report the names of doctors who fail to successfully complete the program.

Medical boards should conduct random audits of institutions to check compliance with these reporting requirements, and should fine those who fail to comply. After a doctor is disciplined, a board should fine any other practitioners who knew of that doctor's offense, but failed to report it.

6. **Keep the courts in check.** Each legislature should pass laws that make clear their intent that the judgements of the medical board be given extreme deference, and that, barring extraordinary circumstances, disciplinary actions should take immediate effect pending appeal.

Each legislature should adopt the 'Preponderance of the Evidence' standard of proof in medical disciplinary cases, replacing the tougher-to-meet 'Clear and Convincing Evidence' standard now in effect in most states. According to the August, 1990 report on state medical boards issued by the Office of the Inspector General, "The 'clear and convincing evidence' standard of proof is more rigorous than the 'preponderance of evidence' standard that is typically required to justify tort damages for negligence

in civil cases. The more rigorous standard provides greater protection for physicians, but adds complexity to the investigative process and appears to make it less likely that a board will persevere on a case through a full evidentiary hearing."[13]

Furthermore, the Project Work Panel of the Federation of State Medical Boards, in its August 1989 report Elements of a Modern State Medical Board: A Proposal, recommended that each state medical board "use preponderance of evidence as the standard of proof" and that they each have the power "to issue final decisions when acting as trier of fact in the performance of [their] adjudicatory duties".[14]

7. **Beef up funding and staffing.** Each legislature should permit the medical board to spend all the revenue from medical licensing fees, rather than being forced to give part to the state Treasury. The medical boards should raise their fees to $500 a year.

All boards could benefit from hiring new investigators and legal staff. Boards should ensure adequate staff to process and investigate all complaints within 30 days, to review all malpractice claims filed with the board, to monitor and regularly visit doctors who have been disciplined to ensure their compliance with the sanctions imposed, and to ensure compliance with reporting requirements.

They should hire investigators to seek out errant doctors, through review of pharmacy records, consultation with medical examiners, and targeted office audits of those doctors practicing alone and suspected of poor care. "Physicians who have problems," comments Department of Health and Human Services Inspector General Richard Kusserow, "have retreated to areas where they cannot be observed."

8. **Require risk management.** States should adopt a law, similar to one in Massachusetts, that requires all hospitals and other health care providers to have a meaningful, functioning risk management program designed to prevent injury to patients. Massachusetts also requires all adverse incidents occurring in hospitals or in doctors' offices to be reported to the medical board.

9. **Require periodic recertification** of doctors based on a written exam and audit of their patients' medical care records.

RECOMMENDATIONS TO CONSUMERS

1. **Complain.** File your complaints about poor medical care or medical misconduct with your state medical board and with the federal Department of Health and Human Services. If the offense occurred in a hospital, also file a complaint with the hospital peer review committee.

Your complaints are needed to protect others!

2. **Organize.** Form citizens' action or victims' rights groups to improve medical quality assurance in your area. The American Association of Retired Persons publishes a guide that can help you mobilize a group for reform.[15] Try to get a representative of your group appointed to the state medical board or the Medicare Peer Review Organization for your state.

3. Write to your Congressperson and voice your support for the opening of the National Practitioner Data Bank to the general public.

Notes

1. Winn, James R. "Official 1989 Federation Summary of Reported Board Actions," FSMB News Release December, 1990.

2. Public Citizen Health Research Group. State Medical Licensing Board Doctor Disciplinary Actions in 1988 July, 1990, p. 1.

3. Public Citizen Health Research Group. 6,892 Questionable Doctors Disciplined by States or the Federal Government June, 1990, p. xiv.

4. Physician Characteristics and Distribution in the U.S. American Medical Association, 1990.

5. Harvard Medical Practice Study Group. "Patients, Doctors and Lawyers: Medical Injury, Malpractice, Litigation and Patient Compensation in New York," 1990.

6. Mills, D. H. ed. California Medical Association and California Hospital Association Report on the Medical Insurance Feasibility Study Sutter Publications, 1977.

7. Journal of Legal Medicine February, 1976.

8. Public Citizen Health Research Group. 6,892 Questionable Doctors, op. cit. p. xxii, Table 3.

9. Schwartz, William B. and Mendelson, Daniel N. "The Role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence," Journal of the American Medical Association 1989, vol. 260, no. 10, pp. 1342-1346.

10. "State Medical Boards and Medical Discipline," Office of Evaluation and Inspections, Office of the Inspector General, U.S. Department of Health and Human Services, August, 1990, pp. 21-23.

11. Lohr, Kathleen N., and Schroeder, Steven A., Institute of Medicine. "A Strategy for Quality Assurance in Medicare," New England Journal of Medicine vol. 322, no. 10, March 8, 1990, pp. 707-712.

12. Federation of State Medical Boards. Elements of a Modern State Medical Board: A Proposal August, 1989.

13. Office of the Inspector General, op.cit., p. 9

14. Federation of State Medical Boards, op.cit., p. 14.

15. American Association of Retired Persons. "Effective Physician Oversight: Prescription for Medical Licensing Board Reform", 1987.

PREPARED STATEMENT OF CLARK C. HAVIGHURST

Mr. Chairman, I am Clark C. Havighurst. I teach and write in the field of health care law and policy at the Duke University School of Law. I appreciate the opportunity to discuss with the subcommittee the problems arising under the law of medical malpractice.[1] Members of Congress have manifested a notable interest in malpractice reform in recent months, and it is useful to consider why medical malpractice, normally a concern of state law, has emerged as a possible subject for action by the federal government.

I. Identifying the Federal Stake

Judging from the conventional nature of most of the malpractice reform proposals currently pending in Congress,[2] the federal government's stake in reforming the law of medical malpractice differs little from that of the states, some of which have entertained similar reforms. In my view, however, the federal government has a much greater stake in the law of medical malpractice than is revealed in the conventional reforms being proposed. I hope to direct the subcommittee's attention to the fundamental problems I see in the standards of medical care utilization that the tort system threatens to enforce against health care providers -- at great cost to us all and to the federal government as well.

A. The Conventional Reform Agenda

A rather long list of possible reforms in the law of medical malpractice has been urged upon the states continuously since the 1970s and upon the federal government from time to time throughout the same period. The most popular reform ideas have been caps on the amount of damages recoverable, especially for noneconomic losses; reductions of awards to reflect amounts received from collateral sources; elimination of punitive damages; the scheduling of damages for particular injuries; periodic payment of damage awards over the duration of the injury; shortened statutes of limitations; the adoption of statutes of repose; limits on attorneys' contingent fee rates; modification of the rule of joint and several liability; miscellaneous procedural and evidentiary changes; and encouragement of the use of alternative methods of dispute resolution. Many of these ideas have been embodied in federal reform proposals. It is not clear, however, why all these matters should not be left in the hands of state courts and legislatures. The federal interest to be served by imposing them is not strong, and the federal government's constitutional power to preempt state law for such purposes is not obvious.

Convincing arguments can be advanced on behalf of many of the reforms on the conventional agenda. Some of the reforms respond to doubts concerning the reliability of lay juries in establishing provider fault, causation, and the

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[1]Portions of this statement have been adapted from Havighurst, "Practice Guidelines as Legal Standards Governing Physician Liability," 54 L. & Contemp. Probs. 87 (Spring 1991).

[2]The characterization as "conventional" does not apply, however, to S. 1232, 102d Cong., 1st Sess. (1991) (introduced by Senator Pete V. Domenici), which has several unique features and which is commented upon at the end of this Statement. See Havighurst & Metzloff, "S. 1232 -- A Late Entry in the Race for Malpractice Reform," 54 Law & Contemp. Probs. 179 (Spring 1991).

appropriate level of damages, especially for noneconomic losses.[3] In addition, several of the proposed reforms seek to reduce the high administrative costs of resolving claims through an adversarial evaluation and litigation system. Such costs are very high. Indeed, of the $7 billion paid into the system each year as liability insurance premiums, only about $3 billion actually end up being paid as compensation to injured patients, the rest being consumed in litigation and administration.[4] Finally, all of the reforms are aimed in some measure at keeping malpractice risks insurable -- at some bearable cost -- so that providers can safely continue to provide essential health services. In varying degrees, the reforms on the conventional list have been advocated by the medical profession and the health care industry and resisted by consumers and plaintiffs' lawyers. Even so, several of them have merit as practical solutions to problems that are significant though not overwhelming.

Despite the arguable merits of several of the reforms on the wish list that physicians have brought to their state legislatures and to Congress, it is not clear that the federal government stands to gain very much from any of them, and it is difficult to claim that any of the reforms being contemplated go to the heart of national health policy. Moreover, the subtance of tort law and the administration of justice in state courts are matters that are traditionally left in the hands of state courts and legislatures.[5] Finally, the direct financial stake of the federal government in the malpractice system cannot be very great. The federal government bears only a part of the $7 billion total cost of malpractice coverage, and it is unlikely that more than a small portion of that cost is avoidable by changed rules or improved procedures.[6] Despite the federal government's possible perception that the states are too slow to adopt desirable malpractice reforms, federalism considerations usually preclude federal interventions in state affairs solely on the basis of such policy disagreements.

Of course, the federal government might elect to adopt certain of the

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[3]Not all of these concerns are clearly justified by findings of empirical studies, which suggest that juries are fairly adept at finding fault but unpredictable in measuring damages. See, e.g., Metzloff, "Resolving Malpractice Disputes: Imaging the Jury's Shadow," 54 Law & Contemp. Probs. 43, 80-86 (Winter 1991) (empirical study with limited data from the possibly unrepresentative state of North Carolina, concluding that "defendants do not often lose cases on the merits where their insurers [relying on expert assessments] expected to win" and that, based on the data, "it is no wonder that the insurers' files are replete with grumblings about the difficulty of predicting jury awards").

[4]See P. Weiler, Malpractice on Trial 99 (1991): "In its own terms, malpractice law is quite costly, now requiring about $7 billion of insurance expenditures in order to deliver approximately $3 billion of benefits to a select group of injured patients, with an indeterminate impact on both the quality and the utility of the treatment provided to patients." See also P. Danzon, Medical Malpractice: Theory, Evidence, and Public Policy 186-87 (1985) (reporting estimates of the share of the premium dollar ultimately received by injured patients as low as 18% and Danzon's own estimate of roughly 33%).

[5]The federal government can, however, perform a useful role in gathering information and sponsoring research and demonstrations.

[6]Indeed, better, more efficient procedures for resolving malpractice cases could induce the bringing of more claims, as lawyers lower their contingent-fee rates and increase their willingness to accept small cases. That there are many negligently caused injuries unredressed by the current system is established in Harvard Medical Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York 6 (1990) (finding 15 out 16 cases of negligence uncompensated).

conventional reforms in its own financing programs, such as Medicare and Medicaid.[7] Moreover, if the federal government elects to assume responsibility for all health care under a single-payer system, then it should certainly consider what kind of regime to establish to deter substandard provider performance and to resolve claims of provider malpractice. Under current circumstances, however, the cost and availability of malpractice insurance and the questionable performance of the adjudicatory system alone do not give the federal government a clear warrant for interfering in state judicial processes or in the definition of substantive tort rights.

B. The Problem Usually Labeled "Defensive Medicine"

Although I do not believe that policy concerns, however warranted, about the cost of medical liability insurance and the administration of the law of medical malpractice provide an adequate basis for congressional preemption of state authority, there is another feature of the tort liability system that has a profound impact on the federal government and its ability to discharge its recognized responsibilities. The heading under which this issue is usually discussed is "defensive medicine."[8] That rubric does not, however, fully identify the source or the seriousness of the problem to which I wish to direct the subcommittee's particular attention. The conventional reform agenda, being focused only on the cost and availability of liability insurance and the reliability of adjudicatory processes, does not even approach the core of the problem as I see it. I believe that the federal government's responsibility for reforming the law of medical malpractice lies here -- and only here.

In my view, Congress's recent interest in malpractice reform reflects an emerging but still incomplete realization that malpractice law operates as a cost-increasing regulatory program affecting all medical care in the United

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[7]Thus, the federal government might conclude that the medical care it finances directly through public programs such as Medicare and Medicaid should be evaluated under more efficient, more reliable procedures or should be subject to an entirely different regime of quality assurance. Congress miught therefore, in the interest of efficiency and uniformity, mandate an alternative method of dispute resolution for all claims brought by federal beneficiaries and might impose some limitations on their substantive tort rights. See, e.g., S. 1232, supra note 2; H.R. 4566, 101st Cong., 2d Sess. (1990) (introduced by Representative Nancy Johnson). (Both bills would require alternative dispute resolution in all cases involving Medicare beneficiaries.) Alternatively, it might elect to save the high costs of fault finding and to ensure compensation for more injuries by subjecting Medicare and Medicaid providers to some form of no-fault liability; a current proposal to adopt a form of strict liability for particular injuries is particularly attractive because it would maintain incentives to prevent bad outcomes of medical treatment. See, e.g., Tancredi & Bovbjerg, "Rethinking Responsibility for Patient Injury: Accelerated-Compensation Events, A Malpractice and Quality Reform Ripe for a Test," 54 L. & Contemp. Probs. 147 (Spring 1991).

[8]"Defensive" medical care is provided less for the patient's benefit than to protect the physician from exposure to possible malpractice liability. Unnecessary tests and treatments that are provided only to satisfy an unreasonable standard of care that the physician imagines some future plaintiff's lawyer might assert is widely believed to be a major contributor to high medical costs. See generally Hershey, "The Defensive Practice of Medicine: Myth or Reality?," 50 Milbank Memorial Fund Q. 69 (1972); Project, "The Medical Malpractice Threat: A Study of Defensive Medicine," 1971 Duke L.J. 939-48. See text at note 8 infra for a broader definition of "defensive medicine" that comes closer to capturing the full significance of the cost-escalating pressures that emanate from malpractice law and third-party financing.

States, including not only care that the federal government finances directly but also that which it subsidizes at considerable expense through the tax system. Under tort law as we know it, the health care system is driven to conform to regulatory standards governing the utilization of services that are not necessarily in the public interest. Although malpractice standards are generally assumed to provide appropriate guides for medical practice under all circumstances, they have been developed without input from the consuming public by parties who are accountable to the public neither through the political process nor in the competitive marketplace. Having been drawn from the industry itself and particularly from the practicing medical profession, the malpractice standard of care has never been subjected to the tests of cost-effectiveness that public policy normally applies before embracing particular regulatory measures. Because tort law drives the system to incur large and often questionable costs, the standards it sets and threatens to enforce against all providers in the event of a mishap should be subject to some public or private scrutiny and control.

The federal government is appropriately concerned with the possibility that the standard of care enforced against health care providers by malpractice courts causes inappropriate spending in public programs -- perhaps exceeding by far the $7 billion annual cost of operating the malpractice system itself. It should also be concerned that malpractice law, like regulation in other settings, effectively circumscribes consumer choice, forcing people to purchase Cadillac-style medical care when they might rationally prefer lower-cost basic protection under which the few increased risks they run are more than justified by the cash savings they enjoy. Most serious of all, Congress should recognize that malpractice law contributes to pricing millions of Americans out of the market for private health insurance altogether. With providers bound by law to deliver only high-cost, state-of-the-art services, American consumers have only two essential options in the market for health coverage: Either they must purchase some version of the mandatory Cadillac -- that is, an entitlement to first-class, state-of-the-art care, or else they must "go bare," without health insurance in a potentially cruel world. Too many have had to make the latter choice.

I wish in these remarks to develop the hypothesis that the American health care industry is overregulated by the judicial system, with grave consequences for both the cost and accessibility of medical care, and to argue that only Congress can effectuate the necessary deregulation of the standard of care. Unlike the conventional agenda for malpractice reform, the reforms I propose go to the heart of American health policy.

II. Malpractice Law as a Form of Regulation of Medical Practice

With all the attention paid to the law of medical malpractice in recent years, it is surprising that it is so rarely characterized or analyzed as a system of command-and-control regulation. Although tort law operates only after an injury has occurred, its prospective, regulatory character is apparent in its application of prescriptive standards to determine provider fault as a prerequisite of liability. Like conventional regulation, malpractice law has sanctions that effectively compel observance of its requirements. Even though malpractice insurance relieves physicians of the direct financial cost of injuries caused by their negligence, malpractice suits are costly to defendants in other ways.[9] To avoid entanglement with the legal system, most physicians

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[9]Although malpractice insurance is usually not experience-rated, physicians with multiple claims may anticipate difficulty in retaining coverage as well as adverse consequences in their dealings with hospitals, other physicians, and regulatory authorities. Malpractice suits are highly stressful and distracting to physician defendants and expose them to harmful publicity. An additional sanction for malpractice was added by the Health Care Quality Improvement Act of 1986, which requires that all payments made in settlement of malpractice claims be reported to a federally maintained data bank. 42 U.S.C. §11131 (1988); 45

strive to conform their behavior to what they perceive to be the law's expectations. Indeed, they typically give the law a very wide berth, erring consistently on the side of overspending. Although only excesses beyond the law's actual requirements are typically labeled "defensive medicine," waste may also be built into the the law's regulatory requirements themselves. In compelling an excessive commitment of societal resources to the regulated activity, malpractice law reveals a defect commonly found in command-and-control regulation.

Because the prospect of being sued for substandard performance is intended to, and apparently does, influence physician performance, malpractice law is similar in its impact to prescriptive regulation.[10] Even though most analysts treat malpractice law on its own terms as a matter of individual rights, it is more helpful for policy purposes to analyze it as essentially a regulatory program. The federal government has a particularly strong interest in recognizing the pervasive cost-increasing effect of malpractice law-cum-regulation.

A. The Deficiencies of Regulatory Standards Drawn from Customary Medical Practice

The substantive standards that the tort system currently employs in regulating medical practice are drawn, ostensibly at least, from phsycians' "customary practice." The law's reliance on medical custom, local or national, as its source of substantive standards is, however, difficult to justify as a matter of public policy. First, it assumes that physicians, left to their own devices, generally practice in ways that are socially correct. Yet health services research has disclosed that medical practice, instead of reliably gravitating toward uniform methods reflecting deep scientific understanding and careful weighing of all options, varies inexplicably not only between geographic areas but even within the same community.[11] This heterogeneity of medical practice gives expert witnesses in malpractice cases great freedom in opining on the standard of care. Any questionable performance by juries in assigning fault in malpractice cases must be attributed in part to the law's reliance on a source of standards that is incapable of producing anything precise and predictable enough to be worthy of the name.

Even when medical custom yields relatively clear standards for regulating medical practice, their substantive validity may still be open to serious question on scientific or economic grounds. The weak scientific underpinnings

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C.F.R. §60.7 (1990). Such black marks will presumably affect physicians' future prospects adversely.

[10]For an inconclusive discussion of the question of the impact of liability risks on physician behavior, see Harvard Medical Practice Study, supra note 6, ch. 9. "Physicians of a given specialty with a higher perceived risk of being sued were more likely to order more tests and procedures than their colleagues with a lower perceived risk." Id. at 29-30. The phenomenon of "defensive medicine," while difficult to measure, suggests that the law does indeed influence physician conduct, though possibly in some inappropriate ways.

[11]The work of John Wennberg, M.D., revealing the variability of medical practice is now well known. See, e.g., Wennberg, "Dealing with Medical Practice Variations: A Proposal for Action," Health Affs., Summer 1984, at 6, 7; Wennberg & Gittelsohn, "Small Area Variations in Health Care Delivery," 182 Sci. 1102 (1983). See also Chassin et al., "Variations in the Use of Medical and Surgical Services by the Medicare Population," 314 New Eng. J. Med. 285, 286-87 (1986);

of much conventional medical practice have been widely noted.[12] In addition, medical custom is a poor guide to what is economically justified.[13] Customary medical practices have evolved in the United States under systems of paying for medical care that create economic incentives for both physicians and patients to overutilize services, spending more on marginal benefits than they are in any sense worth. For the tort system to enforce rigid adherence to practice norms arising spontaneously under an incentive system fraught with "moral hazard" is thus to convert an inefficiency that may be acceptable as a necessary cost of financial protection into a mandatory burden on society.[14] A proper definition of "defensive medicine"[15] would include not only wasteful efforts by physicians to make themselves look good before a jury but also conscientious efforts to follow practices of the professional community that have become customary despite their inappropriateness in terms of benefit/cost ratios.

Although cost considerations have intruded more and more into medical decision making in recent years (through managed-care initiatives, for example), it is doubtful that the health care system has learned how to balance benefits against costs in any coherent way. Indeed, malpractice fears are regularly cited as a reason why physicians cannot be more cooperative in cost-containment efforts. In theory, of course, the legal system should be able to detect shifts toward more economical practices and to excuse physicians who follow such shifts. Even in theory, however, tort law allows departures from dominant practice only after the new practices have come to be followed by a so-called "respectable

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[12]See, e.g., Eddy & Billings, "The Quality of Medical Evidence: Implications for Quality of Care," Health Affs., Spring 1988, at 19, 20 ("for at least some important practices, the existing evidence is of such poor quality that it is virtually impossible to determine even what effect the practice has on patients, much less whether that effect is preferable to the outcomes that would have occurred with other options"); Eddy, "Clinical Policies and the Quality of Clinical Practice," 307 New Eng. J. Med. 343 (1982) ("there is reason to believe that there are flaws in the process by which the profession generates clinical policies").

[13]In tort actions in nonprofessional fields, courts generally treat the custom of a trade with respect to safety measures as relevant (though not conclusive) evidence of appropriate care, partly because such evidence suggests what precautions have generally been found to be worth their cost. See W. Landes & R. Posner, The Economic Structure of Tort Law 131-39 (1987); Bovbjerg, "The Medical Malpractice Standard of Care: HMOs and Customary Practice," 1975 Duke L.J. 1375, 1384-1407. Because of the way medical care has long been financed, there is no comparable basis for assurance that what one sees in practice is efficient or socially appropriate.

[14]Moral hazard arises whenever one person (e.g., a doctor or a patient) is in a position to spend or risk resources belonging to another (e.g., a health insurer). See P. Joskow, Controlling Hospital Costs: The Role of Government Regulation 22-24 (1981). As Joskow explains, inefficiency attributable to moral hazard may be an acceptable cost of financial protection against unpredictable medical needs as long as payers have taken all cost-effective steps to minimize that cost. Ironically, however, once an inefficient standard of care has become entrenched through the influence of moral hazard, malpractice law requires providers to spend whatever it calls for. See Bovbjerg, supra note 13, at 1392-97. Likewise, payers will find themselves legally bound, under contracts that explicitly or implicitly incorporate professional norms by reference, to continue paying for care that would not be ordered if costs were faced.

[15]See note 8 supra.

minority" of physicians.[16] Thus, in theory as well as practice, the legal system continues to expose innovators to serious liability risks. In addition, without clear standards, juries often remain free as a practical matter to find liability solely on the basis that more could have been done for the individual patient.

In general, the idea of drawing regulatory standards from prevailing practice would seem distinctly ill-suited for an industry that is heavily impacted by insurance-induced moral hazard and gravely in need of fundamental changes in practice styles.

B. Can Practice Guidelines Improve the Quality of Regulation Through the Tort System?

To some extent, the poor quality of regulation imposed by malpractice courts on health care providers has been identified and responded to in the emerging movement to develop "practice guidelines."[17] Practice guidelines are systematic, scientifically derived statements of appropriate measures to be taken by physicians in the diagnosis and treatment of disease. They are currently being developed in the private sector, aided in some measure by federally sponsored outcomes and effectiveness research and overseen to a limited extent by the federal Agency for Health Care Policy and Research.

Practice guidelines are widely viewed as a potential panacea for many of the health care industry's most pressing problems. In particular, they are being viewed hopefully as a way to ameliorate problems associated with medical malpractice. The quality of claims resolution by the legal system should certainly improve as a result of both the greater clarity of guidelines in comparison to the vagueness of current legal standards and their probable substantive superiority. In addition, the cost of defensive medicine will be reduced if physicians are better able, with practice guidelines, to estimate the limits of their legal duties. There is thus some reason to believe that practice guidelines can eventually improve the tort system's regulatory performance, if that is how society chooses to use them.

It remains to be seen, however, how often practice guidelines will be clear and specific enough to establish a standard of care usable by juries in malpractice cases and by physicians in making clinical decisions that will stand up in court. Even if a court admitted a particular set of guidelines as evidence of the applicable standard of care, the guidelines might not be conclusive. A plaintiff's or defendant's counterevidence to the effect that actual practice in the physician community differed from some specific guideline norm would presumably also be admissible. Moreover, if the guidelines left significant room for alternative practices or allowed variation within a range -- as

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[16]See, e.g., Chumbler v. McClure, 505 F.2d 489, 492 (6th Cir. 1974): "The test for malpractice and for community standards is not to be determined solely by a plebiscite. Where two or more schools of thought exist among competent members of the medical profession concerning proper medicial treatment for a given ailment, each of which is supported by responsible medical authority, it is not malpractice to be among the minority in a given city." See also Bovbjerg, supra note 13, at 1408-14.

[17]See generally Institute of Medicine, Clinical Practice Guidelines: Directions for a New Program (1990); Physican Payment Review Commission, Annual Report to Congress 1989, at 219-36 (recommending federal support for effectiveness research and development of practice guidelines); Havighurst, supra note 1; Havighurst, "Practice Guidelines for Medical Care: The Policy Rationale," 34 St. Louis U.L.J. 777 (1990) (discussing movement and federal guidelines program).

professionally developed guidelines in particular will often do[18] --, a plaintiff might attempt to litigate which practices, within the permissible range, were customary in fact. For example, if availability of financing induced physicians generally to practice at the "top" end of the specified range, the guidelines might provide no certain defense for care that met only the minimum standard. Or specialists might be held to the higher standard as a matter of course. On the other hand, a physician who met only the minimum standard but could demonstrate that it enjoyed some acceptance might be exonerated under the rule recognizing custom among a "respectable minority." The same exception might even be invoked in defense of conduct falling outside the guidelines altogether. For these reasons, it seems clear that, at least as long as courts follow the narrow logic of the customary-practice rule, guidelines will not eliminate as much uncertainty, or save as much in litigation expense, as they would if the guidelines were more precise and embodied in a statute or binding regulation.

Practice guidelines may fail to provide as much malpractice protection to physicians as is hoped. One possible outcome is that juries will treat almost any injury-causing violation of a guideline as negligence per se even if it is not regarded as such in law. Moreover, the situation might not be symmetrical, so that compliance with a guideline might not be as likely to insulate a physician from liability. For example, a plaintiff might be entitled to have his case submitted to a jury if he could offer credible evidence that, even though the applicable guideline was complied with, it was too general to define appropriate care in the particular case. He might also assert that custom required doing more than the minimum required by the guideline or that the guideline minimum was itself a negligent standard.[19] Because juries may be swayed by sympathy for the plaintiff or by distrust of physicians and their possibly self-serving standards, a finding of liability might result even if the physician acted in reasonable reliance on the guideline. Even if legislation expressly exonerated physicians complying with applicable guidelines, the situation might not improve materially, because a plaintiff could frequently allege that a guideline was inapplicable to the particular case because of some circumstance not contemplated by the guideline makers.[20] Under these

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[18]Profession-sponsored guidelines will usually focus primarily on establishing floors (below which care may be deemed inadequate or incompetent) and ceilings (above which care may be deemed unnecessary and unreimbursable). The range between these boundaries -- or "parameters," as the AMA calls them -- will tend to be fairly wide except where the scientific evidence supporting a particular course is very clear. Not only would a professional organization be reluctant to rule out any practice supported by an appreciable number of its members, but one of its prime goals would be to protect the clinical freedom of practitioners. Although professionally promulgated boundaries of acceptable practice would be of some help in detecting overuse, underservice, and professional negligence, such guidelines would usually be more permissive than guidelines developed with input from consumer interests concerned only about raising quality and containing costs.

[19]Cf. Helling v. Carey, 519 P.2d 981 (Wash. 1974) (finding prevailing customary standard negligent).

[20]Recent legislation in Maine, 1990 Maine Pub. Laws ch. 931 (Apr. 24, 1990), attempts to maximize the protective benefits of guidelines while eliminating the mandate to conform by providing that the guidelines are inadmissible to establish negligence; "only the physician or the physician's employer may introduce into evidence as an affirmative defense the existence of the practice parameters and risk management protocols . . . ." Earlier federal legislation that was designed to accomplish a similar purpose failed to give physicians any meaningful protection, perhaps because it provided immunity only if the physician "exercised due care in all professional conduct" related to such actions. 42 U.S.C. §1320c-

circumstances, it is not clear that "defensive medicine" will be obviated by practice guidelines. Practitioners may not find enough comfort in them to economize even when the guidelines suggest that it is responsible to do so.

Another question concerning practice guidelines as standards for regulating the health care system is whether and how they will allow cost considerations to be taken into account in treating patients. Just as customary practice standards rarely reflect anyone's careful comparison of benefits and costs, professional organizations engaged in setting explicit practice standards have no reason to give cost considerations appreciable weight. Indeed, physicians regularly assert ethical reasons for not taking costs into account in either treatment decisions or standard setting. Instead of addressing difficult trade-offs between marginal quality and marginal cost, most guideline developers will focus their attention exclusively on medical issues, pretending that economic trade-offs either do not exist or are someone else's responsibility. There is a real danger, therefore, that practice guidelines developed by professional organizations will further standardize medical care just at a time when greater flexibility and contractual freedom are necessary to permit responsible economizing. Perhaps the most that can be hoped for is that the profession's guidelines will not actively foreclose responsible economizing measures that physicians and health plans might take independently.

Because of uncertainties about how practice guidelines will be employed in courtrooms, it cannot be concluded that they will rectify all the regulatory deficiencies of the law of medical malpractice. A more serious question, however, is whether improved regulation is what consumers most need. I now turn to a possible deregulation agenda.

III. Deregulating Health Care: Guidelines as the Final Piece of the Puzzle

Although most observers view practice guidelines as a way of improving the tort system as a regulatory program, the real problem, in my view, is that medical practice is overregulated, not just badly regulated, by tort law. Thus, I would take issue with the view that the tort system's only need is a better universal benchmark for evaluating a physician's actions than customary medical practice, the law's current source of standards. In my view, if the development of practice guidelines were fostered with a deregulatory, decentralizing objective in mind, the health care system in general and malpractice law in particular could move out of their traditional command-and-control mode and allow consumer choice an expanded role in bringing about badly needed new initiatives in cost containment.[21] Specifically, I envision private contracts in which consumers, a payer, and participating providers agree on selected practice guidelines as specifying their respective rights and obligations. Public programs, too, could incorporate selected guidelines as a way of putting limited resources to their best uses.

A strategy of letting consumers, acting through their employers and other agents, choose the utilization standards that would govern their personal care would have been highly impractical in the past. The practice guidelines movement, however, opens up possibilities for making and specifying choices that did not previously exist. In time, consumers and their agents may have available

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6(c) (1983). Whether because of this clause or because "peer review organizations" (PROs) did not develop norms as precise and prescriptive as practice guidelines are expected to be, this immunity provision has been essentially inoperative. (No cases are cited in the annotation in 42 U.S.C.A. §1320c-6 (1983 & Supp.), and no cases were found in a WestLaw computer search.)

[21]This thesis is developed more fully in my articles cited in notes 1 & 17 supra.

to them a variety of practice guidelines reflecting different readings of the scientific evidence and different conclusions on many of the quality/cost trade-offs that health care presents. By incorporating selected guidelines in contracts, they could specify, as they never could before, just what health services they do and do not wish to purchase from providers on a prepaid basis. To the extent that the current regulatory character of malpractice law is attributable to the practical difficulty of adopting any alternative to professional norms and standards of care, the practice guidelines movement could eventually supply the new tools that are necessary to effectuate the deregulation of medical practice and the re-enfranchisement of the health care consumer. The first prerequisite for a successful deregulation strategy is thus the development of a variety of reliable, pluralistic guidelines that reflect independent judgments on the many issues relevant to sound consumer choices.

Another vital ingredient of a successful deregulation strategy is a legal system that, instead of automatically defining the obligations of health professionals in universal terms, contemplates that the physician's duty in a given malpractice case might be found in the contract between the physician and the patient.[22] Of course, if the physician/patient contract was not specific as to the physician's duties, then the norms and standards of the profession as a whole should be read into the agreement by implication -- just as under current law. But if the parties can fairly be said to have chosen a different regime of responsibilities and rights, courts should then foreswear their customary regulatory stance and allow the parties' choices to control. In my view, courts could be persuaded to accept private choices if they were made responsibly and clearly reflected conscientious efforts to purchase health care wisely with appropriate regard for the limits of the resources available.

A final question, obviously, is what role the federal government could play in bringing about a decentralization of decision making on crucial standard-of-care issues. First, it is vital that the practice guidelines movement be encouraged to develop along pluralistic lines. Federal funding should therefore be used, not to develop a single set of guidelines for each area of medicine, but to foster the development of competing guidelines. In addition, the guidelines program in the AHCPR should be expanded and directed to function not as the final arbiter of medical practice but as a certifier of practice guidelines that meet minimum standards for scientific reliability, objectivity, and disclosure of the basis of the choices made. Certified guidelines would recommend themselves not only to consumers and their agents but also to courts, which must be persuaded that a contract they are asked to enforce according to its terms was reasonable and in the consumer's own initial interest and was not an attempt by a payer to shortchange plan subscribers.[23]

With respect to malpractice reform, I would like to call the subcommittee's attention to S. 1232, Senator Domenici's "Medical Injury Compensation Fairness Act of 1991."[24] That bill is virtually unique in addressing the vagueness and inefficiency of the legal standard of care traditionally employed in judging negligence in malpractice suits. Instead of mandating a particular change in the legal standards currently appearing in state law, however, the bill contemplates and expressly invites privately negotiated variations in the substantive standards by which malpractice liability is determined. Indeed, it specifically

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[22] The terms of this contract might be found in the arrangement between the patient and an organized health plan with which the physician is affiliated in some capacity.

[23] For a full discussion of how the federal guidelines program could assist in deregulating the standard of care, see Havighurst, supra note 17.

[24] For a fuller discussion, see Havighurst & Metzloff, supra note 2.

anticipates that federally certified practice guidelines might be adopted in private health plans and serve as the standards applicable in future malpractice actions. By indicating the receptivity of the federal government to alternative standards that might be independently specified either for federal health care programs or in private contracts between consumers and health care providers, the bill should cause courts to go along with the alternative liability rules so specified. Even though the purpose of S. 1232 is to effectuate quite radical changes in a dysfunctional legal system, its method is not to legislate all such changes but to establish a new framework within which both procedural and substantive rights could evolve through the efforts and interaction of the parties affected.

I view S. 1232 as a highly constructive effort to find solutions to some serious problems in American health care. Its most original and significant feature is the considerable room it leaves for parties to public and private health plans to introduce reforms of their own design, thus altering by private contract procedural and substantive rights that have heretofore been generally prescribed by the legal system alone. This move to endow the private sector with the freedom to create new procedures and different legal relationships represents a significant challenge to the paradigm that has previously dominated decision making on medical care issues in the United States, generally curtailing the role of consumer choice.[25] The explicit recognition and exploitation of the contractual character of health care in Senator Domenici's bill is notable. In my view, the idea of expanding the effective realm of private choice might be usefully incorporated in any federal proposal that seeks more general reform of American health care.

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[25]See generally Havighurst, "The Professional Paradigm of Medical Care: Obstacle to Decentralization," 30 Jurimetrics J 415 (1990).

PREPARED STATEMENT OF ROBERT E. MCAFEE

Mr. Chairman and Members of the Subcommittee: My name is Robert E. McAfee, MD. I am a practicing general surgeon in Portland, Maine and Vice Chairman of the Board of Trustees of the American Medical Association (AMA). Accompanying me are Hilary E. Lewis, JD, of the AMA's Group on Legislative Activities, Martin J. Hatlie, JD, of the AMA's Office of the General Counsel, and Gordon Smith, JD, General Counsel, of the Maine Medical Association. On behalf of both the Maine Medical Association and the AMA, I am pleased to have this opportunity to testify regarding the very serious problems that stem from our litigious society.

The current tort system as it exists in most jurisdictions does not accomplish either of the goals of dispute resolution—compensation for those injured due to negligence and deterrence of such negligence. The system is fraught with inequities. In fact, medical liability litigation, accurately dubbed "high stakes" litigation by the RAND Corporation, has created numerous problems for this country's health care system—all to the detriment of patients, physicians, health care providers, society and the federal government (the largest single payor for health care in this country).

DEFINING THE PROBLEM

For many years, this country has grappled with the growing inability of the tort system to resolve medical liability claims in a timely and effective manner. The debate has intensified during the past two decades as medical liability problems have reached crisis levels in many states, and as society has shouldered the "side effects" of the crises.

In the 1990s, the issue of medical liability remains heated, and we are at a point where action is needed. Studies conducted by the Harvard School of Public Health, the Bush Administration's Council on Competitiveness, President Reagan's Tort Policy Working Group, the General Accounting Office (GAO), and the Department of Health and Human Services Task Force on Medical Malpractice and Insurance, just to name a few, concur with the following consensus: the current tort system, without substantial modification or reform, is unable to resolve medical liability claims effectively and efficiently.[1]

It also is important to note what the problem is not—medical negligence is not solely the fault of "bad" or "incompetent" doctors. Rather, studies have shown that all doctors, even the best doctors, can and do make mistakes. We submit that avoidable mistakes are never acceptable. The medical community—and the medical liability insurance community—is committed to continuing efforts to reduce the incidence of injury even further. Our efforts alone, however, are not enough to remedy the many harms that the current tort system perpetuates.

Maine Medical Society Liability Demonstration Project—A unique and innovative local response to the liability crisis is best demonstrated by the Maine Medical Association's medical liability demonstration project. Based on considerable problems that were identified in Maine, an unusual coalition was formed to develop constructive responses to a liability problem that had reached the crisis stage.

Legislation in Maine was enacted in 1990 that creates an atmosphere where practice parameters and risk management protocols will be developed in four specialty areas: emergency medicine, anesthesia, radiology and obstetrics and gynecology. Under this law, physicians electing to participate in the demonstration project will be able to use compliance with the standards as an affirmative defense in any medical liability suit brought against them during the five years of the demonstration project. By tracking liability claims for five years and by comparing data from this period with the previous five year period, determinations will be made on the efficacy of using parameters and risk protocols as an affirmative defense. As of January 1992, the right to utilize the affirmative defense will become effective, and liability claims will be tracked until the end of 1996. (See Appendix A for a description of this program.)

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[1] These studies also reached agreement that the reform model adopted in California most effectively discourages frivolous claims, promotes settlement of valid claims and expedites claims resolution. These reforms include:

(1) limitations of $250,000 on recovery of noneconomic damages;
(2) mandatory offset of collateral sources of plaintiff compensation;
(3) decreasing sliding scale regulation of attorney contingency fees; and
(4) periodic payment for future award of damages.

PATIENTS ARE HARMED

The AMA strongly believes that patients who have been injured due to negligence should be fairly compensated, and that our dispute resolution mechanisms should promote this goal. Unfortunately, the current tort system has failed the patient population.

A February 1990 study by the Harvard School of Public Health of hospital admissions in 1984 shows that of the 1% of patients whose medical records indicated some negligent treatment, only 12.5% filed liability claims. significantly, only half of those patients—6.25%—received compensation from the tort liability system.

Other data show that even when patients pursue compensation, other parties to the system reap disproportionate benefits. Attorneys fees and expenses (both plaintiff and defendant) account for 38% of total monies spent on resolving medical liability claims. (See Appendix B.)

Ironically, while our system ostensibly is designed to compensate the injured, the RAND Corporation estimates that only 43 cents of every dollar spent in medical liability litigation reaches injured patients.

In addition, patients typically wait much too long for resolution of their claims—six to ten years in most urban areas. The time and cost commitment involved in pursuing litigation denies injured patients meaningful access to the legal system by discouraging attorneys from accepting cases where damages are not expected to be very high.

PHYSICIANS ARE HARMED

Medical liability awards soared by more than 1000% from 1960 to 1984. A study reported in 1988 showed that the average doctor has a 37% chance of being sued for professional liability in his or her lifetime. This increases to 52 percent for a surgeon and 78 percent for an obstetrician.

Perhaps the most compelling evidence of the current system's failure is the fact that *a physician's chance of being sued for medical liability bears little relation to whether he or she has been negligent.* The Harvard data show that 80% of the claims for medical negligence filed in New York did not correspond with a negligent adverse event. stated differently, of those plaintiffs who sued their doctors, only 20% had cases based on evidence of a negligent adverse event. These findings reinforce the GAO's estimate that nearly 60% of all claims filed against physicians are dismissed without a verdict, settlement or any payment of compensation in the plaintiff's favor (1987 GAO Report "Medical Malpractice, Characteristics of Claims Closed in 1984"). The message implicit in these facts and figures is that the current tort system as it functions in most states is not effectively resolving medical liability claims or deterring medical negligence.

SOCIETY IS HARMED

Costs—Although patients, physicians, and health care providers are most directly harmed by the present liability system, society as a whole also is harmed. The spiraling costs generated by our nation's dysfunctional liability system are borne by everyone. One component of the cost issue is the exorbitant amount attributable to physicians' (and other providers') professional liability premiums, which have been a primary factor contributing to recent years' growth in patients' medical and health care bills. In the 1980s, professional liability premiums were by far the fastest growing component of physicians' practice costs, increasing at an annual average rate of 15.1% between 1982 and 1989. (see Appendix C.) Average premiums paid by self-employed physicians tripled in the 1980s. The cost is especially heavy for some high-risk specialists whose premiums have reached as much as $200,000 annually.

Yet another aspect of the liability cost factor is the cost attributable to the practice referred to as "defensive medicine." Aptly named, defensive medicine is a phenomenon whereby physicians, faced with a 38% chance of being sued regardless of the quality of care they provide, defend against future liability claims by providing services in cases where that care might not have been provided absent the fear of litigation. A study published in Medical Economics found that, as a result of this practice, 70% of physicians order more consultations, 66% order more diagnostic tests, 54% order more follow-up visits and 28% perform procedures they ordinarily

would have delegated to other medical personnel. The AMA estimates that this practice added an additional $15.1 billion to the cost of health care in 1989.[2]

Medical Innovation—Another societal harm that results from the present system is that the threat of liability inhibits medical innovation and deprives health care professionals of certain pharmaceuticals and medical devices needed to optimally treat patients. Excessive litigation costs was the primary cause for the manufacturer of the morning sickness drug Bendectin to withdraw this product from the market, even though to this day there is no credible scientific evidence linking it to birth defects. There also is no substitute therapy for morning sickness that has been developed—the litigation risk is just too high.

As President Bush noted last year at John Hopkins University, in a speech which called for restoring "common sense fairness" to the medical liability system: "No risk means no progress, and that's not the American way." Yet "no progress" is precisely what this country risks if the present litigation system is allowed to continue unfettered. We are also heartened by the Vice President's attempts to engage the American Bar Association in the liability reform debate.

Access to Health Care—Perhaps the most serious societal harm aused by the liability system is reduced access to health care. Increasing premiums and the threat of liability have caused physicians to abandon practices and certain services in various areas of the country. This is not a phenomenon limited to rural areas. Last month, Senator Riegle, while chairing a hearing on health system reform, indicated that his family is unable to remain with the obstetrician of choice because that physician has given up obstetric practice. This did not happen to a citizen in a rural community. It happened to a U.S. Senator in the District of Columbia.

Access by all Americans to health care has become a serious national priority that appropriately is receiving unprecedented interest and support. Almost daily, headlines reflect the progress of the many commissions and advisory groups that are studying the access problem and proposing solutions, including Secretary Sullivan's Internal Health and Human Services Task Force, the U.S. Bipartisan Commission on Comprehensive Health and the Social Security Advisory Commission. Access to health care also occupies the forefront of our concerns at the AMA as we proceed with our pioneering Health Access America reform plan, our proposal to ensure universal access to and affordability of high quality health care. (See Appendix D.)

The flurry of current legislative initiatives on the subject of health system reform, both at the federal and state level, underscores the need for resolution of this issue. However, health care reform cannot be successfully achieved unless the irrationality and the hemorrhaging costs of the current medical liability system also are addressed.

The AMA urges this Committee to recognize that the current professional liability system significantly and directly impairs access to health care. Until the negative aspects of the liability environment are alleviated, the access issue never will be fully resolved.

THE FEDERAL RESPONSE

The medical community is actively carrying out its responsibility to work toward a solution to the medical professional liability disaster. We hope that the other participants in the system will heed the call to participate in this effort. We believe, however, that a contributor to any viable solution must be the federal government.

Many states have been unable to effect reforms that can withstand state constitutional challenges. It should be noted, however, that the basic reform models contained in the various medical liability bills introduced in the 102nd Congress have withstood federal constitutional challenges under the Equal Protection, Due Process, and Right to Jury Trial Clauses of the U.S. Constitution.

The litany of problems with the current tort system does not necessarily mean that the system must be abandoned. We believe that a fault-based system that lowers the barriers to legitimate claims and reduces transaction costs can meet the needs of society. Reforms such as those adopted in the states of California and Indiana tell us that the current system is a good candidate for reform, and that reform can produce dramatic effects by promoting' settlement of valid claims, discouraging frivolous litigation and reducing the time required for claims resolution.

Federal Preemptive Tort Reform—The federal legislative initiatives which have been introduced on the subject of medical liability reform in 1991 offer many con-

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[2] Like other defensive measures, all defensive medicine cannot be characterized necessarily as overuse, but can reflect necessary improvements in patient care.

structive solutions to some of the most perplexing and serious issues in the medical liability arena.

The AMA applauds provisions in the bill sponsored by Senator Hatch, S. 489, "Ensuring Access Through Medical Liability Reform Act of 1991," which would create incentives for the states to enact tort reforms that: (i) impose a cap on noneconomic damages of $250,000; (ii) require mandatory periodic payments of damage awards in excess of $100,000; (iii) allow offsets from damage awards for payments made through collateral sources; (iv) create a decreasing sliding scale regulation of attorney contingency fees; (v) prescribe a reasonable statute of limitations, especially as applied to the claims of minors; and (vi) provide for expedited settlement procedures.

A number of other bills also call for similar reforms, including the Bush Administration proposal, S. 1123, the "Health Care Liability and Quality of Care Improvement Act of 1991," and the recently introduced "Health Care Injury Compensation and Quality Improvement Act" sponsored by Senator Durenberger and Senator Danforth. The comprehensive approach taken in the latter bill to address liability concerns associated with manufacture of drugs and medical devices represents another constructive step in addressing these issues. The AMA supports these various innovative efforts to make the issue of medical liability reform a matter of national priority by the Congress.

Alternative Dispute Resolution Systems—The AMA believes that a fault-based administrative system, such as the one designed by the AMA/Specialty Society Medical Liability Project (AMA/SSMLP), may provide a forum and process for dispute resolution that is more fair to both claimants and defendants, more cost-effective, and more systematic in deterring medical negligence and promoting patient safety than the present system. We are pleased to note that an intensive analysis of the AMA/SSMLP model recently completed by the Georgetown University Centers for Medicine and Law corroborates these expectations. (See Appendix E). We applaud the fact that experimentation with alternative dispute resolution occupies a major role in the various federal proposals advanced to date. The bill sponsored by Senator Domenici, S. 1232, "Medical Injury Compensation Fairness Act of 1991," to remove most medical liability claims from the traditional tort system, represents a constructive approach that should be explored and studied on a limited basis.

Funding—While the pending liability proposals offer many creative solutions to the complex issues addressed, the funding mechanisms in the current measures introduced have raised a number of concerns. For example, S. 489 would appropriate $279 million over a 3-year period with each state receiving a $5 million share. Its companion bill, H.R. 1004, would allocate $280 million to states, based on their population. The "Health Care Injury Compensation and Quality Improvement Act" would provide a .04 percent Medicaid bonus per calendar quarter to states with eligible ADR systems. S. 1123 would create a bonus pool available only to those states that enact the required medical liability reforms.

The AMA stands opposed to any funding mechanism based on population as it would severely disadvantage smaller states which have demonstrated a readiness to pursue experiments in ADR. Similarly, the modest Medicaid bonus of .04 percent also would fail to provide a sufficient incentive for smaller states to pursue experiments in dispute resolution. The AMA also opposes the withholding of Medicare/Medicaid funds to penalize states that fail to enact tort reform as constituting a severe disincentive to constructive liability reform.

Patient Safety/Risk Management—Provisions in the current federal legislative initiatives to enhance patient safety would serve as a valuable adjunct to the other reforms proposed. The AMA supports the dedication of health care professional licensing fees to increase the effectiveness of state medical disciplinary boards. We also support the ability of states to enter into contracts with local professional societies to investigate consumer complaints. Absent the threat of antitrust exposure and protected by a grant of sovereign immunity, peer review activities will be heightened.

Efforts to involve liability insurers, hospitals, medical societies and states in risk management programs may serve to further enhance patient safety. The AMA believes that any risk management activity must be carefully undertaken so that the physician's responsibility to provide quality patient care remains paramount. Physicians must be actively involved in developing and participating in risk management activities in order to achieve the goal for which they are created—the provision of quality patient care. The medical profession remains committed to reduce the incidence of patient injury. In this context, we support required risk management train-

ing for health professionals and are taking aggressive endeavors to restrict the ability of unethical physicians to practice medicine.

Agenda for Civil Justice Reform in America—The August 1991 Report from the President's Council on Competitiveness, "Agenda for Civil Justice Reform in America," contains a number of recommendations which the AMA endorses. In articulating the need for procedural reform in the courts, the Report focuses on the $300 billion indirect costs of the civil justice system and $80 billion in direct litigation expenses, as well as the protracted nature of the legal process. It also recognizes an appropriate role for alternative dispute resolution systems in addressing the problems of costs and delay. The AMA/Specialty Society dispute resolution proposal evolved from similar concerns relating to the time and expense of litigation.

THE MEDICAL COMMUNITY'S RESPONSE

Mr. Chairman, all parties—patients, lawyers, physicians and insurers—must be willing to make compromises to craft an effective solution to the professional liability problem. We agree that the responsibility is a shared one, and acknowledge that it is the provider community's particular responsibility to do whatever it can to minimize the incidence of avoidable patient injury. (See Appendix F.)

Providing medical care today involves a complex system of persons and technology, each individual and component of which is necessary to bring about the safe and effective delivery of care to the patient. All of our activities aim at the common goal of preventing patient injury. All call upon us to examine what we do or fail to do, and how we do it. When problems are detected, solutions are developed and implemented.

We strongly believe that the patient safety movement currently being implemented by the medical community is the optimal source of information and education for providers on injury prevention issues. These activities are data-based, innovative and amenable to modification as new problems arise. To best prevent errors, we must study the facts of loss situations, identify high-risk circumstances and educate physicians in a focused manner on how to avoid them.

CONCLUSION

Mr. Chairman, the problems associated with excessive litigation are not new to the medical profession. The medical liability bills being considered today, the recommendations of the President's Council on Competitiveness, the Harvard Medical Practice study and virtually every other study that has been completed all validate what physicians have been saying for 15 years—the system is broken. It needs to be fixed.

It needs to be fixed to meet the needs of the injured patients who need to be fairly compensated, the physicians who are willing to assume their fair share of the burden from negligent practice, and society, which needs to reduce transaction costs, eliminate windfall judgments and assure that physicians can still offer medically necessary services in an atmosphere of fairness to all parties.

The Maine Medical Association and the AMA appreciate the opportunity to appear before this Committee. At this time, we will be pleased to respond to questioning.

APPENDIX A—MAINE'S LIABILITY DEMONSTRATION PROJECT—RELATING LIABILITY TO PRACTICE PARAMETERS

[By Gordon H. Smith, Counsel, Maine Medical Association]

On April 24, 1990, Maine Governor John R. McKernon, Jr. signed into law Public Law 1990, Chapter 931, the Maine Medical Association's medical liability legislation which includes a 5-year medical liability demonstration project. The purpose of this article is to set forth the history, purpose and scope of the project. The Association's medical liability legislation included collateral source reform, the creation of a Rural Medical Access Program subsidizing obstetrical rates in underserved areas and the 5-year medical liability demonstration project. The project grew out of discussions within the so-called Healthcare Roundtable which is made up of the Maine Chamber of Commerce and Industry, Blue Cross-Blue Shield of Maine, the Maine Hospital Association, the Maine Medical Association, the Maine Ambulatory Care Coalition (representing rural health centers) and the Maine State Employees Association (the public employee union in the State). These parties were brought together in 1988 in response to the alarming increase in the cost of health insurance. The group has met on a regular basis and has initiated legislation and other projects aimed at reducing the cost of health insurance.

In the meetings of the Healthcare Roundtable, the practice of defensive medicine was identified as one of the factors leading to increased health care costs. Although the amount of defensive medicine is difficult to quantify, all participants believed that because of an unfavorable liability climate, physicians were ordering more tests and procedures in order to "cover all the bases" and protect against claims and permit better defense of liability claims that were filed. The American Medical Association has previously estimated the cost of defensive medicine to be as much as $11.7 billion annually. The essence of the liability demonstration project lies in the premise that physicians cannot be expected to change their practice patterns unless they are given some protection in the liability area. Participants in the discussion believed that if practice parameters and risk management protocols could be developed for some of the areas where defensive medicine is believed to be most rampant, such as the emergency room, and if physicians were immunized from suit if they practiced in accordance with the standards, the costs of defensive medicine could be decreased. Legislation establishing the project was drafted by the Medical Association in 1989 and presented in January 1990 under the sponsorship of State Senator N. Paul Gauvreau. Because the project was innovative and represented a positive approach aimed at reducing health care costs, the Legislature quite enthusiastically embraced the project and enacted it with other tort reforms during the last day of the 1990 legislative session. Only the trial lawyers opposed the project.

At one time or another, at least four medical specialties were considered for participation in the project. Representatives of anesthesia, emergency medicine, cardiology and obstetrics and gynecology all were consulted and expressed some interest. By the spring of 1990, however, the project ultimately focused on anesthesia, emergency medicine and obstetrics and gynecology. The specialties of anesthesia and obstetrics and gynecology were chosen because of the well-established standards that have already been promulgated nationally. Emergency medicine was chosen because of the interest in getting at the cost of alleged excessive diagnostic procedures in the emergency room. Participating physicians in these three specialties will have their liability claims tracked from January 1, 1992 through December 31, 1996. Physicians electing to participate will be able to assert compliance with the established practice parameters and risk management protocols as an *affirmative defense* in any medical liability case brought against them as a result of alleged medical malpractice occurring during the five years of the project

The practice parameters and risk management protocols will be developed by physicians appointed to medical specialty advisory committees in each of the specialty areas. The appointments will be made by the Board of Registration in Medicine with some assistance from the Board of Osteopathic Examination and Registration, the Governor's office and legislative leadership. There are six members of the medical specialty advisory committee on anesthesiology, including four anesthesiologists. The fifth member is an insurance representative and the sixth member a consumer representative. The medical specialty advisory committees on emergency medicine and obstetrics and gynecology consist of nine members each, six of whom are physicians with the remaining members representing insurers, consumers and allied health practitioners. In the latter slot, a certified nurse midwife has been appointed to the OB-GYN advisory committee and a nurse with extensive experience in risk management has been appointed to the Emergency Medicine advisory committee. The Board of Registration has recently named the physician appointments to the committees which are expected to begin work on the protocols almost immediately. The committees will propose the protocols and parameters to the Board of Registration in Medicine by early 1991. By March 1, 1991, each medical specialty advisory committee will provide a report to the Legislature, setting forth parameters and protocols developed and adopted by the Board. In drafting the protocols and parameters, the committees will consult with the respective national medical specialty organizations as well as the A.M.A. Office of Quality Assurance.

Because the Board will actually adopt the parameters and protocols as rules under the Administrative Procedures Act, the parameters and protocols will have the force and effect of law for those physicians practicing in the demonstration project. However, only the physician will be permitted to admit the parameters and protocols into evidence in a malpractice case. The parameters cannot be used affirmatively against the physician unless he raises the issue in the law suit. The statute provides that,

> "In any claim for professional negligence against a physician or the employer of a physician participating in the project in which a violation of standard of care is alleged, only the physician or the physician's employer may introduce into evidence as an affirmative defense the existence of the

practice parameters and risk management protocols developed pursuant to the project."

In essence then, the physician will have the benefit of a known standard that cannot be challenged by experts within or outside the State. However, the participating physician is not bound by the standard in a case in which he has deviated from the protocol or the parameter. In such an instance, the issue of the existence of the parameter or the protocol simply will never come up in the litigation.

Although the right to use the affirmative defense will begin on January 1, 1992, and continue for five years, the project will not take effect in any specialty unless 50% of the physicians practicing in that specialty in the State elect to participate. Each physician will be given the chance to participate by filing notice with the Board of Registration in Medicine by November 1, 1992. Each physician, therefore, will have the opportunity to review the parameters and protocols prior to making an election. Becau5e the medical specialties involved lobbied for the legislation and supported the project, it is hoped that the desired level of participation can be achieved.

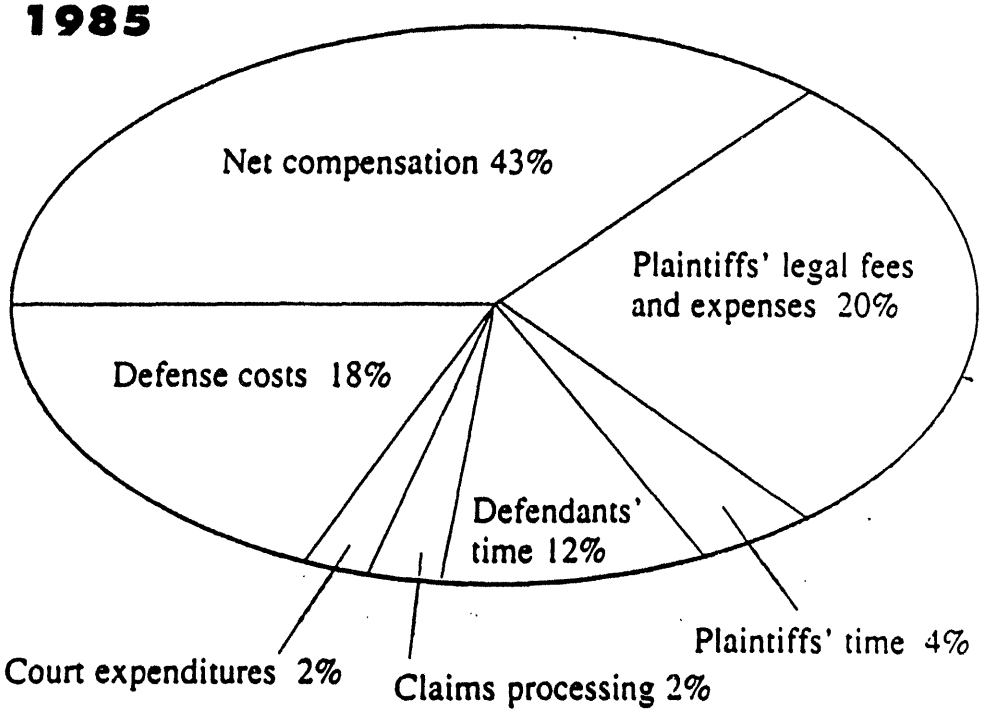
Obviously, the goal of the project is to decrease both the cost of defensive medicine and the participating doctors' liability risk. With respect to the development of the practice parameters and risk management protocols, some costs could increase and some could decrease, depending upon what standards are set. The Board of Registration in Medicine has appointed an Economic Advisory Committee which will establish a methodology for evaluating the effect of the project on cost, utilization and practice of defensive medicine. It is hoped that this project will complement a project in defensive medicine currently being developed by the Maine Medical Assessment Foundation. The Foundation's project would focus on three conditions which are likely to encourage defensive medical practices—head injuries, chest injuries and spinal injuries.

In addition to the promulgation of the practice parameters and risk management protocols, the Maine Liability Demonstration Project requires reports by malpractice insurers to the Bureau of Insurance, including enough information for the Bureau of Insurance to make adequate comparisons between the claims data collected during the project and the data in the five years preceding the project. The Bureau of Insurance and the Board of Registration in Medicine must report the results of the project to the Governor and the Legislature by December 1, 1997.

As the initial phase of the project begins, several questions have emerged which must be resolved as the project takes shape. First of all, can the advisory committees devise parameters which are both general enough to be accepted by the profession but specific and narrow enough to be useful in the defense of a malpractice claim? Secondly, given medicine's general distaste for "cookbook" medicine, will the requisite number of physicians elect to participate? Related to the second question is the issue of how many physicians the Board of Registration in Medicine will consider as practicing in the given specialty inasmuch as Maine does not license physicians by specialty. The specialty of emergency medicine poses the most difficulty in this regard. Finally, because of the relatively small number of physicians practicing in the selected specialties in Maine, the statistical base necessary to make any profound conclusions concerning whether establishing parameters and providing liability protection reduces health care costs or liability claims or losses may not be present.

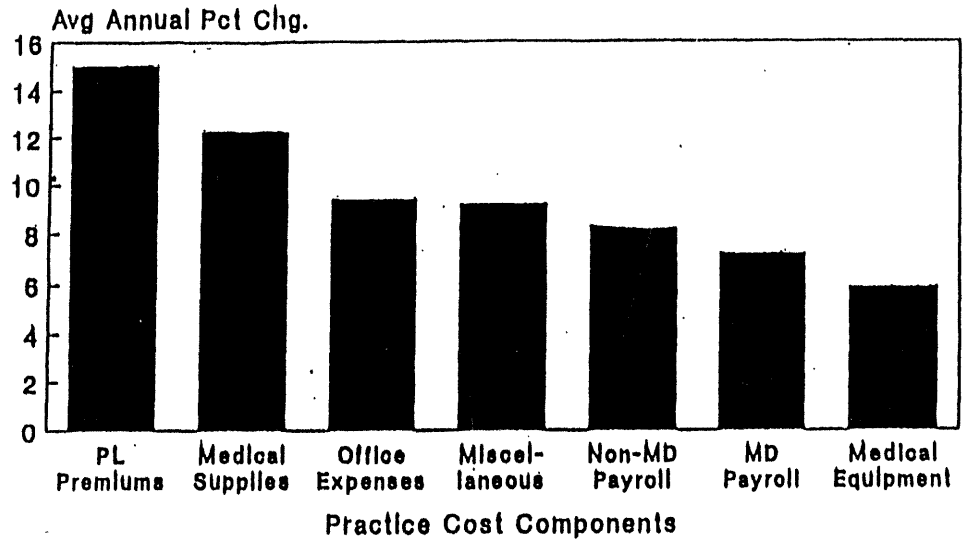
Successful resolution of the above issues will ultimately determine whether the traditional axiom of, "As Maine goes, so goes the nation". . . will apply or instead it modern counterpart, "As Maine goes, so goes New Hampshire, and sometimes Vermont". . .

Plaintiffs' Net Compensation and Various Costs as a Percentage of Total Expenditures in Average Non-Automotive Torts (Including Medical Liability Claims), 1985



Note: Percentages are based on the average of two estimates, and may not sum to 100 due to rounding.
Source: The RAND Corporation Institute for Civil Justice.

Growth of Medical Practice Cost Components from 1982 to 1989



	Annual Percent Growth
Professional liability insurance premiums	15.1%
Medical supplies	12.2
Office expenses	9.4
Miscellaneous[1]	9.2
Nonphysician payroll	8.3
Physician payroll	7.2
Medical equipment	5.9

SOURCE: American Medical Association Socioeconomic Monitoring System, 1983 and 1989 core surveys. Data include self-employed nonfederal, nonresidence patient care physicians.

[1]Includes all items not included in other components.

APPENDIX D

HEALTH ACCESS AMERICA

The sixteen-point proposal

The AMA proposal is a blueprint for extending access, controlling inappropriate health care cost increases, and sustaining the Medicare program to assure proper health care for all. It is summarized as follows:

1. Effect major Medicaid reform to provide uniform adequate benefits to all persons below the poverty level.

2. Require employer provision of health insurance for all full-time employees and their families, creating tax incentives and state risk pools to enable new and small businesses to afford such coverage.

3. Create risk pools in all states to make coverage available for the medically uninsurable and others for whom individual health insurance policies are too expensive and group coverage is unavailable.

4. Enact Medicare reform to avoid future bankruptcy of the program by creating an actuarially sound, prefunded program to assure the aging population of continued access to quality health care. The program would include catastrophic benefits and be funded through individual and employer tax contributions during working years. There would be no program tax on senior citizens.

5. Expand long-term care financing through expansion of private sector coverage encouraged by tax incentives, with protection for personal assets, and Medicaid coverage for those below the poverty level.

6. Enact professional liability reform essential to reducing inordinate costs attributable to liability insurance and defensive medicine, thus reducing health care costs.

7. Develop professional practice parameters under the direction of physician organizations to help assure only appropriate, high quality medical services are provided, lowering costs and maintaining quality of care.

8. Alter the tax treatment of employee health care benefits to reward people for making economical health care insurance choices.

9. Develop proposals which encourage cost-conscious decisions by patients.

10. Seek innovation in insurance underwriting, including new approaches to creating larger rather than smaller risk spreading groups and reinsurance.

11. Urge expanded federal support for medical education, research and the National Institutes of Health, to continue progress toward medical breakthroughs which historically have resulted in many lifesaving and cost-effective discoveries.

12. Encourage health promotion by both physicians and patients to promote healthier lifestyles and disease prevention.

13. Amend ERISA or the federal tax code so that the same standards and requirements apply to self-insured (ERISA) plans as to state-regulated health insurance policies, providing fair competition.

14. Repeal or override state-mandated benefit laws to help reduce the cost of health insurance, while assuring through legislation that adequate benefits are provided in all insurance, including self-insurance programs.

15. Seek reductions in administrative costs of health care delivery and diminish the excessive and complicated paperwork faced by patients and physicians alike.

16. Encourage physicians to practice in accordance with the highest ethical standards and to provide voluntary care for persons who are without insurance and who cannot afford health services.

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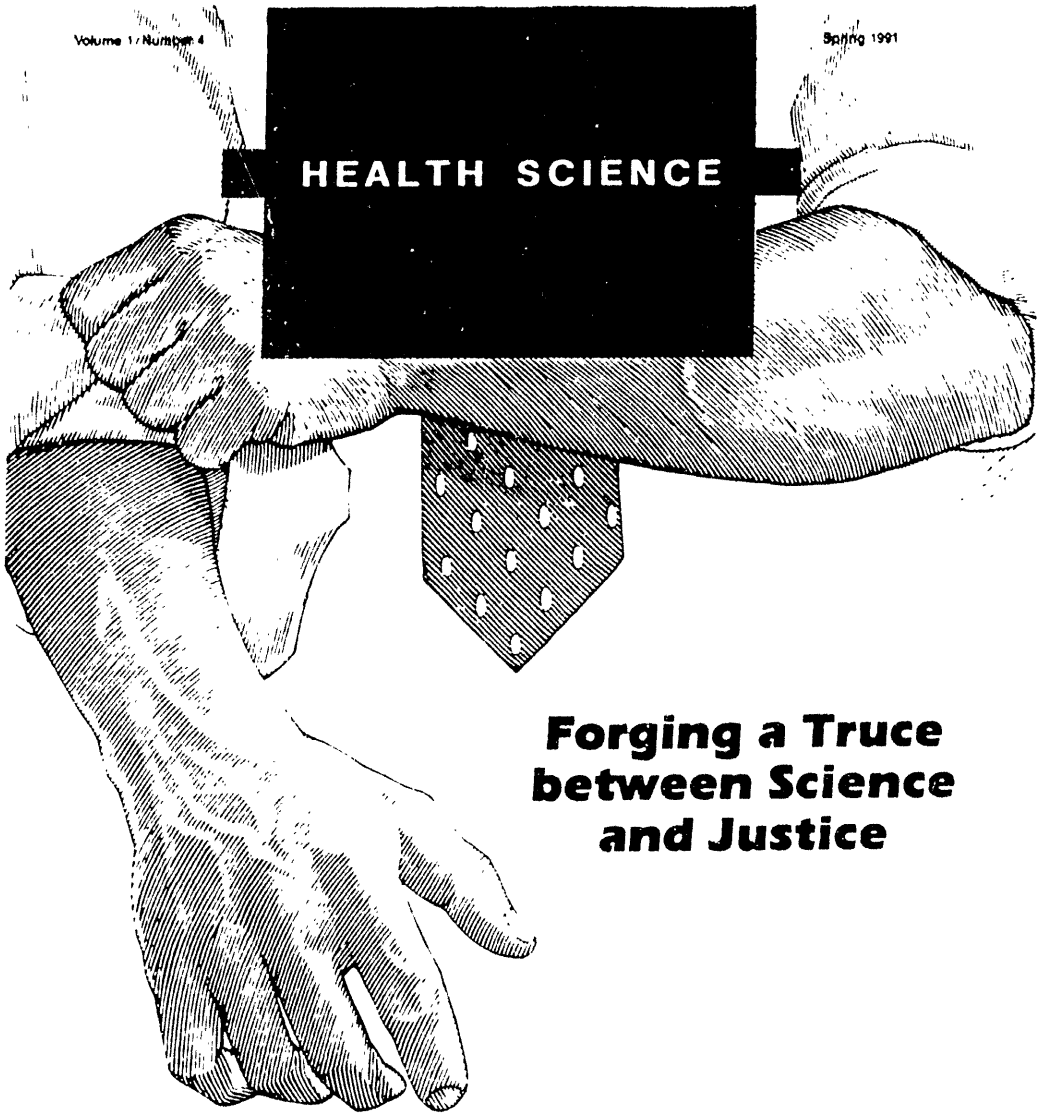
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Forging a Truce between Science and Justice
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Spring 1991, Vol. 1, No. 4

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SPECIAL REPORT

Forging a Truce between Medicine and Justice

The Approach Presented by Organized Medicine's Administrative Alternative for Resolving Medical Liability Disputes

Franklin M. Zweig, Seymour Perry, and Sandra S. Thurston

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On Point

A new dispute resolution mechanism at the state level may be the only escape route from the intractable, no-win conflicts and polarization that now characterize the medical liability litigation system. The plaintiff's bar has much to offer in case finding and robust advocacy but is strapped by high transaction costs from representing small claimants, those who suffer injuries compensable in the $50,000 to $100,000 range. The defense bar wants to maintain the existing system for many reasons, among them the exercise of constitutionally guaranteed rights. The state medical boards appear to be hopelessly enmired; they show little ability to change, and they reduce public confidence in health care quality. The medical insurance industry has passed from commercial to doctor control; accompanying that passage is a nascent but unrealized merger of liability defense with health care quality improvement. Large-claim, mentorious cases may take, on average, 6 years to resolve, and patients and their families suffer the deprivation of both loss and costs until final judgment and award. The federal government has intervened with a claims clearinghouse, but is under shadow of impending conceptual and operational failure.

Organized medicine has proposed a new, cross-cutting administrative agency to reconcile these warring fragments and bring medical professional regulation under nonmedical control while streamlining adjudication, providing free claimant legal representation, and lowering its costs to the public. Georgetown's studies of the proposed legislation to enact a comprehensive, fault-based state agency concludes that a pilot test would be feasible. Orga-

nized medicine, however, must go the extra mile to assure fairness to health care consumers. The agency will need the plaintiff's bar to operate a pilot test. And organized medicine must assume in a new fault-based, administrative agency responsibility for the standard of legal care as well as the standard of medical care. Absent a new institution, however, a truce between medicine and justice seems remote at best. It is in the interest of health care consumers to carefully experiment with such a public policy innovation.

Introduction: Organized Medicine's Alternative: Design and Summary Findings from Six Georgetown Mini-studies

In late 1987, the American Medical Association (AMA), along with 31 medical specialty societies (hereinafter termed "Organized Medicine"), proposed a comprehensive alternative to the existing malpractice litigation system that would substitute an administrative mechanism for determining liability and damages. The proposal was premised upon the medical profession's strongly held opinion that the current system was inherently unreliable and that tort reform efforts had failed to correct its shortcomings. Beyond injured patient compensation, the alternative would retain the fault concept and administratively link claims adjudication to more vigorous professional regulation. In May 1989, organized medicine published a final version of a model statute to implement the proposal.[1]

From the beginning, the proposal has been a target of comment and criticism, in part because of the magnitude of the suggested change. It represents a radical restructuring of the methods by which medical liability is determined.[2] Organized medicine recognizes these factors and proposes that one or more states implement its fault-based administrative alternative on an experimental basis. To date, several states have indicated serious interest, and the United States government has established new mechanisms to support such large-scale demonstration and evaluation efforts.[3]

It is difficult to predict how the overall system will operate in practice.[4, 5] Understandably, policy makers often can be reluctant to consider enacting a major institutional change since they do not know how it will work. At the same time, one cannot definitively determine its impact without implementation.

To assist such authorities, Georgetown University undertook a prospective analysis of the proposal. The analysis took the form of six mini-studies. Each mini-study, summarized in Table 1, inquired into an aspect of the proposed administrative alternative.

From the information pool generated by the mini-studies, we addressed several guiding questions posed at the study's outset: How fair is organized medicine's proposal when compared with the current judicial resolution of medical negligence suits? How comparatively efficient would it be in adjudicating claims by patients against physicians and other health care personnel? Would the administrative system cost more or less than operation of the courts with respect to medical liability actions? How well would the proposed administrative system utilize medical scientific information in claims resolution? To what extent does the workers' compensation scheme for adjudicating workplace injuries provide a useful model for organized medicine's proposal? What other practical and research issues unaddressed directly in our inquiry should policy makers consider?

This article reports our findings with respect to these questions. The study and the report, like all policy research, is burdened with important limitations.[6] It is intended, however, to contribute to the continuing debate on the merits as well as the feasibility of organized medicine's proposal for a new compensation and professional regulation institution at the state level. This report summarizes underlying assumptions concerning the existing litigation system that inform organized medicine's proposal. It details the proposal itself. It presents findings from the mini-studies that illuminate the proposal's plausible or possible impacts.

The mini-studies conducted to assess the proposal indicate that there is much to recommend it. While desirability and feasibility factors are not completely resolved, and additional inquiry is needed, we conclude that organized medicine's basic approach would be a significant contribution to thought and action in the medical tort field. Detailed in this report's last section, the fault-based, administrative alternative has significant merit, warranting implementation on an experimental basis.

At the same time, the model state legislation underpinning organized medicine's proposal requires amendments. Medicine must go the extra mile to assure perceptions of the proposed agency's fairness. Its fairness centerpiece is guaranteed claimant legal representation, but new standards are needed to implement the guarantees. Such standards are proposed in this article's last section. We also are concerned that the plaintiffs' bar must be brought into the picture, to assure both enactment and agency operational capacity. We strongly suggest that an experimental agency utilize employed counsel for one-half of its clients and the existing plaintiffs' bar for the other half. Equally strongly, we recommend that the proposal provide new incentives for plaintiffs' lawyers to find and bring claimants into the fault-based administrative system. Similar incentives should also be considered for bringing disciplinary proceedings against doctors.

Finally, we conclude from our search of the justice system literature that administrative adjudication could provide a fair and efficient forum for linking claims, medical professional discipline, and reform of rules guiding the tort system. While constitutional challenges are likely and have not effectively been addressed in this study, provision for factual review

Table 1

Focus and summary findings of mini-studies included in a prospective analysis of organized medicine's proposal for a fault-based administrative system to adjudicate medical liability claims and regulate professional practice

Study	Principal Focus	Main Findings
1 4 contracted papers	General expert assessment and feasibility analysis from health policy, health economics, medical tort reform, and plaintiffs' counsel perspectives	From the writers' perspectives, the new agency should be implemented in a willing state. Plaintiff's position was the most negative, especially as concerns jury trial abolition, but concluded that small claimants could be served if administrative proceedings' quality were assured
2 Workers compensation analogue study	Site visit/case study of the Wisconsin agency to determine applicability of claims adjudication and other features followed by a workshop at Georgetown University	Workers' compensation agencies present a useful analogue for the proposed medical agency, and its costs are in line with Georgetown's projected costs of the new agency. Workers compensation in effective state government appears to be fair and efficient
3. Opinion surveys	600 judges and court-related personnel in several surveys on proposition to take medical dispute resolution out of courts and vest it in a workers' compensation-styled agency at the state level	Substantial minorities favored the proposition. Those favoring and expressing neutrality comprised the majority of respondents. Surprising flexibility toward the idea was observed, even among trial judges
4 Delphi survey	29 experts surveyed in a uniform paper-and-pencil questionnaire, followed by a 1-hour interview	A substantial majority judged the proposed new agency would bring efficiency gains and medical-scientific evidence improvements. A majority thought an agency would be less fair than the current system for medical malpractice litigation. Constitutional concerns were advanced by most experts, but a majority believed those concerns could be overcome through amendments to the propcsal
5 Time/cost estimation study	Step-flow simulation of proposed administrative alternative with cost and time comparisons to the current litigation system	The new agency could cut adjudication time in half for resolution of typical claims and reduce it by 20% for profound injury. The public costs—between $2 and $7 million, approximately—would be substantially less than the current system's public costs while providing free claimant legal advocacy
6. Three state case studies	Assessment of tort reform experience of Michigan, Maryland, and Virginia medical tort reform for the administrative alternative	Maryland demonstrated that the new agency could be operated for the study's estimated costs and that medical professional regulation restructuring is desirable. Virginia demonstrated that case settlements were about the same in pretrial screening cases as other tort claims. Michigan showed that a medical tort reform mechanism—arbitration—could, after many years of litigation, pass constitutional muster, but that a voluntary alternative would likely be unused by health care consumers and providers

by an appellate court could strengthen organized medicine's proposal without damage to its central themes and major provisions.

Concerns about the Court-Based Tort System

Organized medicine's proposal is predicated upon a series of assumptions concerning the current litigation system's failure to fulfill the primary goals of tort law, namely: (1) providing compensation to injured patients efficiently and fairly; and (2) establishing appropriate levels of deterrence. These criticisms, while not universally shared, are supported by existing comments from knowledgeable observers.[7]

As noted by one observer of the malpractice system, "the most convincing case against traditional tort practice is that it fails miserably as a compensation

system."[8] With respect to the compensation function, organized medicine noted at the outset of its new institutional design that those suffering small or modest injuries are often precluded from pursuing their claims by the current system. In mid-1990, after the Georgetown assessment had been planned and launched, Harvard University's long-awaited study of New York hospital records was released. It supported earlier studies and long-held suspicions with harder data. The Harvard study concluded that only 1 in 8 of those suffering medical injury had filed claims, and that only 1 in 16 of those filing claims were compensated.[9] According to the U.S. General Accounting Office (GAO), "the need for the injured party to gain access to the system" is one of the primary failures of the tort system. The GAO study indicates that most lawyers will refuse to accept a malpractice case unless the expected recovery exceeds $50,000.[10] Another frequent criticism is that a relatively small proportion of insurance payments ever reach the injured patients, given the high cost of litigation.

Moreover, the awards that are made may not be equitable. Current evidence suggests that malpractice plaintiffs receive awards several times in excess of those received by other types of plaintiffs for the same injury. Even among malpractice plaintiffs, the awards received by plaintiffs with similar injuries vary widely. This unpredictability and lack of uniformity may result from the current system's reliance on the institution of the jury; the unregulated discovery by means of which both sides interpose delay and discovery as tactical ploys; and judicial failure to hold firm trial dates.

These tactical issues are galvanized by a substantive problem: given the disagreement that exists among experts as to the applicable standard of care in most malpractice cases, some observers believe it is not efficient or fair to entrust the outcomes to capricious lawyer negotiation, on the one hand, or to permit lay individuals to make such complex determinations, on the other.[11] By definition, each jury is inexperienced. The presentation of evidence must necessarily start at the basic level, which predictably lengthens the proceedings and causes problems of application of complex scientific information to the case before the jurors.

Some observers argue to the contrary. They point out that medical negligence cases are settled at the same high rate as most other tort cases—90 to 95%—and, therefore, never reach a jury. They argue that the verdicts are not capricious and that the much-discussed liability crisis is illusory or the short-term result of transitional adjustments of the health care and the legal care marketplaces.[12]

The current system also sustains criticism for its failure to provide appropriate signals to deter negligent conduct. Most medically negligent acts are ignored, sending a very inexact signal, one leading physicians to conclude that the system is essentially irrational. These factors appear to increase the prevalence of defensive medicine—medical care provided primarily to guard against future liability claims for less than perfect outcomes.[13]

Organized medicine's proposal is also premised upon the expense inherent in the current system. The transaction costs associated with malpractice litigation are high, both in monetary terms and in the emotional trauma associated with litigation experienced in common by medical professionals and their aggrieved patients. The adversarial process is fundamentally at odds with the cooperation between physicians and patients that is thought to be vital to the provision of quality medical care. The overall expense of litigation is necessarily reflected in high insurance rates and has contributed to the decline in availability of certain medical services.[14] [15] These criticisms collectively pressure for major changes in the current approach to medical negligence adjudication.[16]

To be sure, 50 state legislatures have enacted a wide variety of procedural changes to address many of the problems noted above.[18] The procedural innovations range from required pre-litigation review of claims by pretrial "screening panels" to procedural fine-tuning such as shortening the statute of limitations. Despite over 15 years of procedural tinkering, organized medicine's position is that we still have a litigation system that is expensive, unpredictable, and ill-suited to the task.[19]

Others have recognized these problems and proposed substantive changes in malpractice law, including a number of "no-fault" proposals. No-fault systems offer broader coverage, and they could offer swifter payment, but they may also offer reduced compensation levels.[20]

From our study of the Wisconsin workers' compensation system, discussed later in more detail, Georgetown analysts found that administration of a fault-based agency would cost about the same as no-fault systems, and that the fault-based alternative could probably include free legal representation for claimants as well.

Some observers want to avoid fault-finding, because it requires extensive background information and expert reviews and results in medical professional stigma. To organized medicine, however, no-fault approaches "offend notions of justice and individual accountability by imposing liability on health care providers even when they have done everything humanly possible to treat a patient but were unable to prevent a bad outcome."[21] Moreover, organized medicine's legal leadership criticizes the no-fault approach for failing to serve the deterrence needs of the tort system, for treating malpractice and professional discipline in an unprincipled, unrelated manner, and for its economic infeasibility. Similarly, reliance on private contractual solutions are eschewed—the lack of equal bargaining power between patients and physicians invites additional litigation.[21]

Organized Medicine's Proposal

The AMA/Medical Specialty Society Liability Project, organized medicine's malpractice task force, proposed a complete restructuring of the process by which liability and damages are to be determined. It essentially maintains the current substantive rules defining liability. The following represents a brief synopsis of the salient features of organized medicine's plan.

The Medical Practices Review Board

The proposal establishes a state agency called the Medical Practices Review Board (the "Board") that would adjudicate medical malpractice disputes. In addition to determining malpractice claims, the Board would also handle all disciplinary actions against physicians, as well as serve as a clearinghouse for information concerning physician performance. The seven-person Board would be appointed by the governor and would be comprised of a four "lay" representatives and a minority of representatives from the medical and legal communities. Once constituted, the Board would appoint the agency's other key personnel, including hearing examiners, attorneys, claims reviewers, and investigators. Significantly, organized medicine recommended that the Board could be developed as an outgrowth of existing state disciplinary agencies. Those entities already possess some modicum of relevant medical expertise and would serve to ensure the close coordination of liability determinations and disciplinary actions.

The Claims Resolution Process

Under the proposal, all medical malpractice claims would be removed from the civil justice system and subjected to a closely defined set of alternative procedures administered under the Board's auspices. A fundamental purpose of this alternative is to provide injured patients with greater access to the legal process. This would be accomplished by permitting claims to be filed directly by the injured patient without the necessity of hiring an attorney. However, once established as a nonfrivolous claim, the claimant would be assigned a Board-appointed attorney for the duration of the proceeding.

The claims resolution function, which replaces the conventional jury trial scheme, is divided into four stages:

(1) Pre-hearing Stage. A patient who believes that he or she has suffered an injury caused by a health care provider's negligence could initiate a claim, without legal assistance, by completing a simple form describing the relevant circumstances, within 2 years of the date of injury for most claims. A claims reviewer employed by the agency would then evaluate each claim. A claims reviewer would examine the medical records and interview relevant parties, complete an analysis within 60 days of filing, and conclude that the claim has merit (and goes to the hearing stage) or lacks merit. If found to lack merit, the claim would be dismissed, with an explanation, pending an appeal to a single Board member, who would then conduct a de novo review to decide whether to affirm the dismissal or issue a recommendation that the claim be allowed to proceed. If the Board member concurred in the claims reviewer's recommendation to dismiss, the claimant could pursue the claim with privately retained counsel by submitting a supporting affidavit from an expert attesting that the patient's injury was caused by inadequate health care. Otherwise, the claim would be dismissed.

For those claims found to have merit at this initial stage, the claim would be forwarded to a private physician for review.[32] If this expert review concurred that the claim appeared to be meritorious, the Board would assign it to a hearing examiner. The hearing examiner, who need not be an attorney, would be a full-time Board employee. A major assumption is that examiners would develop, over time, special expertise in dealing with malpractice claims. The claim would also be assigned to a Board-employed attorney, who would represent the patient/claimant without charge. The patient would have the option to retain private counsel in lieu of the Board-appointed staff attorney. If the expert reviewer found that the claim lacked merit, the Board would retain the opinion of a second expert reviewer. If the second expert found merit, the claim would be assigned to a hearing examiner, and staff counsel would be appointed. If the reviewer concurred that there was no merit, the claim would be dismissed. While there is no provision for a claimant to appeal this dismissal to the Board, the patient could still pursue the claim with private counsel, as detailed above, by submitting a supporting affidavit from an expert health care provider.

(2) Hearing Stage. The hearing examiner assigned to the case would supervise all subsequent proceedings. The first, required event is the convening of a Pre-hearing Conference. In order to encourage settlement of claims, the proposal requires that blind settlement offers from the parties be made at this initial Conference. If no settlement is reached, the hearing examiner enters a pre-hearing discovery order limiting the time and scope of discovery. The Proposal provides that ordinarily each party would be limited to 30 interrogatories and three depositions, unless the hearing examiner ordered otherwise for good cause.

After discovery is completed, the proposal anticipates a final pre-hearing conference. Once again, blind offers must be made. Unlike the earlier offers, this round can trigger sanctions, including in the final award "compensation to the offeror of the offerors' costs, expenses, and attorneys fees incurred for all activities subsequent to the final prehearing conference." These sanctions are intended to ensure the seriousness of the settlement offers made at the final pre-hearing stage. If no settlement occurs, the parties proceed to a hearing.

An oral hearing would be held only if requested or

if the hearing examiner believes it would significantly aid in resolving the dispute. A hearing could function much like a conventional trial in that each side would be represented by counsel with evidence introduced by witnesses, subject to cross-examination. The hearing examiner is afforded somewhat greater authority in conducting the proceedings than a civil trial judge, as is befitting the administrative context. A hearing examiner, for example, can directly question witnesses and, if necessary, summon independent medical or legal experts for assistance in resolving contested medical or legal matters.

Following the hearing, the examiner is required to render a written decision explaining the basis for the result within 90 days. The decision will note whether the health care provider is liable for the plaintiff's injury and, if so, how much should be awarded in damages. It is anticipated that written decisions will develop greater consistency and reliability in the decision-making process. Over time, these decisions will create a body of precedent that will expedite settlement of meritorious claims by providing valuable reference points. Also, written decisions should provide for more reasoned damage awards, enhancing decision consistency and avoiding the risk, sometimes attributed to juries, of subjective awards based primarily upon sympathy for the plaintiff.

(3) Board Review Stage. In order to assure consistency every decision shall be reviewed by a panel of Board members, even if no party files a formal appeal or challenge to the decision. In those cases in which no appeal is filed, the Board may "adopt" the decision, at which time it is to be afforded precedential value. An adversely affected party may file a petition to review within 30 days of the hearing examiner's decision. The panel hearing the appeal must accept the facts as found by the hearing examiner if supported by substantial evidence; legal issues are subject to de novo review.

(4) Judicial Review of Board Decisions. Only limited judicial review of the Board's decisions would be permitted to the state's intermediate appellate court.[23] The only basis for appeal is narrowly limited to determinations of whether the Board acted capriciously or arbitrarily or otherwise abused its discretion.[24] The appellate court would have no authority to reexamine the facts, hear new arguments, set medical standards, or determine whether there was malpractice in the specific circumstances of the case. If the court concluded that the Board erred in following the stipulated procedures, the case would be remanded to the Board.

(5) Payment and Delay Prohibition. A physician found liable by the hearing examiner must pay damages within 30 days of the Board's decision. This rapid payment provision is based on the assumption that few decisions will be reversed by the courts. Moreover, by requiring payment before judicial appeal, the proposal eliminates any incentive to appeal as a means of delaying the obligation to satisfy the judgment.

Reform of Legal Rules and Liability Standards

In addition to restructuring the procedural mechanisms for resolving malpractice claims, organized medicine's proposal includes several modifications of the substantive rules affecting the assertion of malpractice claims. The most significant proposed changes include:

(1) Standard of Care. The standard currently applied in most states is based upon customs recognized and practiced in the local community by what similar health care providers customarily do in similar situations.[25] Under the fault-based, administrative proposal, the Board would apply an alternative standard, focusing on whether the challenged actions fell within the "range of reasonableness," to be determined by reference to the standards of a prudent and competent practitioner in the same or similar circumstances.[26] This formulation recognizes that a broad spectrum of medical care is reasonable and should not result in the imposition of liability, it permits health care providers to employ a course of treatment that is recognized as appropriate by a respectable minority of their colleagues. At the same time, this standard frustrates striving toward a national standard of care. Statewide and nationwide care standards underpin the movement to forge medical practice guidelines. Such guidelines, whether official or voluntary, could raise health care quality, lower cost, and provide safe harbors against malpractice charges. Since organized medicine's alternative has been drafted for the states, each state may wish to craft its care standards based upon such considerations.

(2) Causation. The causation standard for determining liability is significantly modified. In many states, when more than one possible cause of the patient's injury exists, recovery is denied unless the health care provider was more than 50% responsible for the patient's loss.[27] Under the proposed standard, recovery is permitted if the provider's negligence is merely a "contributing factor" in causing the injury. The conduct is deemed a contributing factor if it substantially increased the risk of an injury and such injury in fact occurred. Damages would be apportioned according to the physician's degree of fault under a purely comparative responsibility standard. The long-standing rule of joint and several liability would be abolished.

By making providers liable for damages in proportion to their actual responsibility, the suggested standard is more generous to patients than the current law applied in most jurisdictions, since it allows recovery even if causes aside from the physician's negligence are responsible for more than 50% of the injury. At the same time, the "contributing factor" standard is arguably fairer to health care professionals by recognizing the role of preexisting conditions in otherwise negligently caused injuries. It reflects the uncertainty inherent in the practice of medicine and avoids the arbitrariness of cutting off all recovery at a fixed rate of causation.

(3) Informed Consent. The proposed alternative adopts the current minority rule for informed consent. The minority rule evaluates the adequacy of disclosure of information in obtaining consent from the reasonable patient's perspective, rather than the health care provider's perspective. Proponents argue that the reasonable patient standard is fairer to patients, will facilitate greater communication between the patient and health care provider, and will lead to better shared decision making, which may help to reduce the incidence of malpractice. Opponents argue that this feature reduces the fault concept's robustness and provides a safe harbor from liability in the absence of practice guidelines.

(4) Damages. The proposal also urges certain changes in the law of damages. Economic damages will continue to restore injured patients to the position they occupied "but for" their injuries. The proposal provides that specific guidelines would be developed through rule making for the different components of economic damages, including interest rates, work and life expectancy, and the costs of medical, rehabilitative, custodial, housekeeping, and child care services. Hearing examiners would assure greater consistency and predictability by making specific awards for each item of requested damages. In addition, any award of future damages in excess of $250,000 would be paid in accordance with a periodic payment schedule. In general, damage awards would be reduced by collateral source payments, those costs recouped through insurance and lost work payments.

The Model Act also would define and limit non-economic damages. Such damages would be capped at an amount ranging from $150,000 to $700,000, depending upon the life expectancy of the patient prior to the injury. The cap is defined as an amount equal to one-half of the average annual wage in the state multiplied by the claimant's life expectancy. The cap is justified, in part, because of the free legal representation feature for meritorious claims; there is no need for an award of non-economic damages to cover the plaintiff's attorney's fees.

Strengthened Professional Regulation

In addition to its procedural reform and substantive law changes, the fault-based, administrative proposal is also designed to strengthen the process for credentialing and disciplining physicians. It sides with the growing critical chorus charging state medical boards with ineffective and self-serving conduct.[28] It provides an elaborate process, including emergency procedures, for disciplining and suspending incompetent or dangerous physicians.

Additional, more general, efforts are intended to reduce frequency of negligent acts through mandatory participation in continuing medical education and in quality assurance/risk management programs. Under the proposal, the Board would create and maintain a clearinghouse for reports from hospitals, insurers, courts, and physicians. The clearinghouse would receive reports of any settlements or awards made in the claims resolution and any notifications of disciplinary actions taken by other states. Information collected under this proposal may overlap with the reporting already provided for under current federal law.[29]

To promote review of physicians' practices, the proposal includes several types of reporting requirements. These include mandatory biannual hospital review of physician performance in connection with staff privileges and information provision regarding substandard performance. Physicians are required to have adequate insurance coverage or, alternatively, they will have to document the availability of assets that could be used to satisfy an adverse medical liability judgment. Courts in the states are required to report any criminal convictions of physicians. Physicians not otherwise affiliated with an institution that conducts the required biannual credentialing review are required to report directly to the Medical Practices Review Board.

Summary

In a bold sweep of procedural reforms, paid and guaranteed claimant legal representation, substantive law codification, and practice oversight, the proposed administrative alternative promises advantages for health care consumers injured in the course of diagnosis or treatment. At the same time, it would abolish medical negligence as a cause of action and would disable the common law courts from adjudicating such disputes. Policy makers should carefully weigh the trades involved. As our mini-studies suggest, the quid pro quo for the parties appears to be substantial. The tradeoff between use of the jury system and greater access to the legal system and realization of faster compensation is worthy of serious consideration in general. The alternative system is sufficiently thought through to permit a principled, well-evaluated, pilot operation of the administrative alternative.

Papers Contracted with Experts: First Mini-study

The first mini-study conducted at Georgetown University was a collection of four papers contracted with medical malpractice experts reasonably expected to articulate their analyses within a defined sector of the health care community. Randall Bovbjerg, Esq., Urban Institute, was selected to portray consumer interests and insurance considerations within a health policy analyst's perspective. Mary Ann Baily, Ph.D., George Washington University, was asked to assess organized medicine's proposal from the health care economist's perspective. Laura L. Morlock, Ph.D., University of Maryland, was chosen to evaluate the proposal from a medical tort reform perspective. J. Douglas Peters, managing partner in a Detroit, Mich-

igan, law firm, assessed the proposal from the plaintiffs' counsel perspective.

While they were asked to comment on specific issues such as the administrative, fault-based system's fairness and feasibility, the writers were given wide latitude to analyze all of the proposal's features. Each writer found things to admire and reject in the proposal. More important, they independently agreed that the fault-based administrative alternative should be demonstrated in practice.[10]

Health Policy Analysis Perspective: Bovjberg

Bovbjerg placed organized medicine's proposal in a policy reform perspective. A torrent of mid-1970s and mid-1980s changes had been "less of the same," meaning that pro-plaintiff changes accomplished by judicial decision or societal change were rolled back by tort reform. Many states' reforms involved "take-away" proposals that pitted the medical establishment against plaintiffs' attorneys. Despite the seriousness of the malpractice issues, the debate was seldom focused on how to improve the functioning of the tort system.

The fault-based administrative proposal is notable in that it represents a major tort reform contribution. Its comprehensive approach transcends the prior "take-away" mentality; it represents a "major advance" over organized medicine's previous negativism. Rather than being driven by a crisis mentality, the integrated scheme focuses on the problems of civil justice, questions of access to justice, and fairness of results.

Bovbjerg questioned whether the proposal's underpinning critique of the current civil justice system is persuasive. Some criticisms were indeed well-founded. The author cited strong evidence that the current system had failed in its goal of compensating those injured by medical negligence. Current methods for ascertaining damages are inadequate; damages law is quite flexible, and inconsistency among cases results. Bovbjerg generally expressed support for the organized medicine's legal reforms, noting that the proposals were sensible extensions of existing legal trends with respect to the standard of care, the law of damages, and informed consent.

Other criticisms of the judicial system, Bovbjerg emphasized, could not be proven. He questioned whether the proposal had met its burden of showing that the problems with litigating malpractice cases were any more serious than such problems in other litigation contexts so as to justify such special treatment. The proposal's negligence deterrence provisions were less clear; little was known about the relationship between malpractice and deterrence. The proposal's assumptions as to the incompetence of juries, however, could not be directly proven. One can speculate that jurors are biased in favor of plaintiffs, but proof is lacking. While it is difficult to believe that the current system is optimal, many believe that jurors are capable, in most cases, of understanding the issues presented, even if significant time (and hence expense) are required to educate them. More importantly, the relevant question is not simply whether juries are competent, but whether the entire litigation system—which includes the roles played by liability adjusters and attorneys who resolve many cases through settlement—is competent.

While litigation screening panels had promised procedural improvements, they failed to demonstrate them. New, proactive methods are needed to identify claimants. Bovbjerg's primary concern was his "nagging fear" that the administrative system would be predisposed to defendants, owing to the nature of the Board's structure. Questions of the proposal's political feasibility and its constitutional validity turn on its perceived fairness; it cannot appear that the medical profession has "captured" the dispute resolution process. The ultimate question is whether this approach would be perceived as more pro-defendant than the current system. On the other hand, organized medicine deserves a chance to demonstrate its commitment to even-handedness.

Health Law Economics Perspective: Baily

After acknowledging many of current medical negligence dispute system's failures, Baily observed that, in light of so many faults, even a "very flawed alternative could be superior"; the question may not be whether organized medicine's plan is "right," but simply whether it is "better." While answering this limited question was difficult, Baily noted that the proposal had three major potential strengths. First, it would likely result in improvements in enunciating the legal standard of care. Since the medical profession establishes the actual standard of care through its delivery of medical services, it was fully appropriate that the medical community have a more substantial say in the articulation of its legal standard. This was especially true given the imprecision of the current method for ascertaining the applicable standard. While juries may well do their best, the occasional aberrant result can send strong shock waves through the medical community.

Baily predicted that the proposal would improve the tort system's deterrence function. By providing an inexpensive screening mechanism for those suspecting malpractice, the plan should have the positive effect of uncovering previously undetected acts of negligence, especially where the damages were modest. Similarly, specialization of the decision making function almost certainly would promote consistency, particularly with respect to the determination of compensation levels, which appear quite arbitrary at present. This, in turn, could promote the deterrence function.

A third, positive feature is the structured linkage between claims adjudication and quality assurance. Malpractice can fall on a continuum ranging from deliberate error (owing to personal gain or substance abuse) to isolated mistakes. Many of the errors in the middle range stem from careless habits, lack of knowl-

edge, or inadequate skills that could perhaps have been avoided. The proposal deals with the source of the problem through better disciplinary controls and quality assurance programs; it represents a welcome shift in emphasis. Baily observed that attaining a system that considers standard of care issues in light of cost considerations would be a major achievement.

Baily's concerns are straightforward, directed largely to managerial issues. The Medical Practices Review Board's actual implementation almost certainly would be affected by unanticipated impacts. She questioned how the Board's operations could be financed; costs could exceed those of the current system; plaintiffs' attorneys claims screening functions would become a responsibility of the state; an underfunded demonstration would create an unrecoupable credibility loss for the administrative alternative.

Given the Board's structure, Baily worried, there was a risk that a small group of individuals—consisting primarily of the Board members—would control the determination of the applicable standard of care. While many cases are easy to resolve, others present difficult standard of care questions. On the other hand, Baily concluded, the Board's expertise and involvement with quality assurance programs was more likely to "facilitate orderly evolution of the standard of care, so that sensible cost-benefit tradeoffs can be made without fear of litigation." While fault-based systems overemphasize negligence and underestimate adverse outcomes, the fault-based system provides better deterrence than a no-fault system. On balance, Baily welcomed the possibility of the proposal's demonstration.

Medical Tort Reform Perspective: Morlock

Morlock's analysis was based in large part on a comparison of organized medicine's proposal with Maryland's experience instituting a pretrial screening agency. Under the Maryland approach, virtually all medical malpractice claims are submitted to a three-arbitrator panel that addresses both liability and damages. While litigants have a right to return to court and a "normal" trial, there is a presumption that the panel decision is correct. Initial concerns about pro-defendant determinations and large increases in the number of claims filed were unrealized.

In the first 8 years of the program, slightly over 2,200 claims were filed. Only some of the claims resulted in actual hearings; about 50% of the claims were closed without a formal filing with the administrative agency responsible for handling the arbitrations. Of those claims filed with the agency, a large majority settled or were dismissed prior to the hearing. In the remaining cases that went to hearing, the plaintiff prevailed in 40% of the cases. Compared with plaintiff prevalence rates, estimated by the U.S. General Accounting Office at 22%, Morlock concluded that there was no evidence of pro-defendant bias in the Maryland experience, despite the fact that doctors were regularly employed on the panels as decision makers.

Moreover, the pretrial arbitration experience in Maryland was apparently efficient in that it reduced the number of disputes requiring formal adjudication and decreased the average disposition time. Only 2.3% of all claims proceeded to formal trial, about one-half the national average. Similarly, disposition times in Maryland were less than the national average.

These findings favor predictions that organized medicine's alternative can be achieved through an administrative structure. Maryland's system did not cause a flood of claims, nor did it apparently work to deprive meritorious plaintiffs of a recovery. Without evidence of a pro-doctor bias in Maryland's scheme, Morlock stated that the fault-based administrative proposal offered the potential for improving patient access to the system, expecially if it were well publicized.

Two changes would predictably serve to increase the proportion of claims that resulted in an award of compensation: (1) shorter stature of limitations periods would reduce "evidentiary decay" of the case; and (2) availability of an "experienced attorney at no cost" should increase the porportion of successful claims. This prediction could well be a dominant one: in the 2,217 claims filed with the Maryland administrative agency, a total of 1,169 different claimants' attorneys were involved. The experience level of the attorney was "among the strongest predictors of how the claim was resolved: more experienced attorneys were more likely to settle prior to a formal hearing or to resolve the case at a hearing." Morlock also noted serious concern with the recent changes in the Maryland rules. In 1986, the state law was changed to require claimants to present a certificate of merit, and it also imposed a $350,000 cap on non-economic damages. These changes may have triggered an observed 36% claims reduction.

Based upon the Maryland experience, Morlock expected that the administrative alternative—assuming competent implementation—could serve to increase predictability and promote earlier settlement. The key issue for effective implementation is the Board's "degree of success in attracting sufficient resources and well qualified personnel." As suggested by others, serious constitutional challenges would almost certainly be raised. Given the perceived utility of the Maryland experience, the writer suggested that the proposal's sponsors consider an amendment making the proposal nonbinding as a means of escaping constitutional and political distractions.

Morlock concluded that organized medicine's approach to integrating malpractice and disciplinary systems was "potentially a powerful strategy for addressing many of the current problems with physician oversight as performed by state medical boards." Moreover, there was reason to believe that the linkage could be made. Disciplinary effects would not have to

await resolution of a negligence dispute—as is now currently the norm—but could begin while the current litigation was still pending. The potential for developing more detailed information on outcomes to identify suboptimal procedures—in addition to the traditional justification of ferreting out the few "bad apple" doctors—is a major advantage.

Plaintiffs' Counsel Perspective: Peters

Analysis of organized medicine's proposal must take cognizance of the views of the plaintiffs' bar, given their direct stake in the current system and also their role as a proxy for the interest of the general public. While Peters judged that adoption of the administrative alternative did not serve those interests, he did recommend that it be tested on a small scale and that it be directed to stimulate claims from people alleging smaller damages.

Indeed, Peter's analysis was more than critical; he judged that the plan was fundamentally unconstitutional, unfair, and unsound. The proposal, he wrote, "sidesteps hundreds of years of Anglo-American justice" from Magna Carta to Constitution to common law. Peters admitted that the system as presently constituted was far from perfect, noting that it "provides excellent compensation for big injuries, poor or no compensation for small injuries, and no compensation for those who do not realize they have a claim."

Aside from matters concerning dispute resolution policy, Peters' most defined criticism concerned the institutional incompetence of administrative agencies. This criticism stemmed from several observations. First, little in the history of medical disciplinary agencies suggested any ability to perform the tasks to be assigned under the Model Act's provisions. These are the same agencies that were "chronically underfunded, understaffed, [and] undermotivated in their task of tackling physician discipline." Second, managerial obstacles were pervasive: if claims were added involving issues often more complex than competency issues, the Board's performance could only deteriorate.

Serious questions were also raised about staffing the Board. If an anticipated, desired increase in claims were realized, would the Board conceivably have enough attorneys and hearing officers to handle the increased number? Would the staff attorneys be provided sufficient funds to retain competent experts? Would they have time to do the necessary research?

Given the proposed, arbitrarily shortened limitations on discovery, the author suggested that the quality of representation almost certainly would be lower than currently observed. This would likely create unfairness.

As one example of unfairness built into the Medical Practices Review Board's Model Act, Board attorneys are apparently limited to using in-state experts while defendants remain free to retain any expert. Given the likely difficulty of obtaining in-state experts to testify against their friends and colleagues, these equitable concerns are great.

Finally, Peters questioned the ability of state-employed hearing officers as well as their potential lack of independence. While law firms have the option of increasing or decreasing their resources depending on the number of cases they have, Peters noted, the Board would not have that flexibility, given the constraints of government shortages and budgetary dictates. Such inflexibility could lead to a diminished work product or chronically overburdened staff.

> "In sum, the act's design is fatally flawed and probably irreparable. To emulate or build on the crumbling foundation of state medical boards; to create a closed economic funding system; to create built-in conflicts of interest between act lawyers and claimants; to give boards the power to enact rules and regulations and define standards of care which are beyond appellate review; to fail to provide a basis for determining staffing levels. . ." [will assure the Board's failure].

Georgetown's Findings: Contract Paper Implications and Five Additional Mini-studies

Contract Papers' Cross-Cutting Implications

Peters' critique and the other writers' analyses contributed, in part, to an analytic scheme for the empirical and secondary studies Georgetown deployed in its efforts to provide an even-handed, if prospective, assessment of organized medicine's alternative. Peters' analysis implies an irremediable, economically powered, professional state-of-war among physicians, attorneys, and patients. The only people not organized to play these war games, Peters and the others agree, are the small claimants whose injuries attract little interest from other players. Harvard's data from New York hospital records suggest that small claimants lack access to the legal game. As a group, they seem to be older and lower income people.

Peters and the other three contracted analysts agree on one additional theme: empowerment of the small claimant is desirable, and organized medicine's proposal for a fault-based administrative agency could open windows of access opportunity for such empowerment. But with such high stakes already implanted in a working-but-unsatisfactory, socially costly, medical negligence system, some observers believe that the uncertainty created by a new institution would fuel conflict unless the actors in the current system are provided a stake in charting a new one.

Others regard such a view as a self-fulfilling prophecy, antithetical to rational thought. If an agency such as the administrative alternative were to bring peace and cooperation to patient-physician relations, with the assistance of legal services, through objectively and perceivedly fair procedures and standards, this view holds, the public interest surely would be served.

Georgetown's six mini-studies imply that the ad-

ministrative alternative could be crafted to satisfy both views—the war game view and the rationalistic, health policy view. It is not necessary to make a choice between one and the other. While such accommodation may be difficult to achieve, and while a truce between medicine and science may take some time to gel, we conclude that the goals are achievable within the general design offered in organized medicine's administrative, fault-based proposal. To lay a foundation for this theme, we summarize here our mini-studies' findings. In this article's last section, we extrapolate from those findings the modifications needed in organized medicine's Model Act to accommodate both the war game and the rationalistic perspectives.

Findings from the Five Additional Mini-studies

- The administrative alternative is designed to borrow from the best practices and procedures of the workers' compensation systems in Georgetown's study of such an expert agency.
- The administrative alternative can feasibly be adapted from the workers' compensation experience of good government states such as Wisconsin.
- Both the Wisconsin Division of Workers' Compensation and an opportunistic review of the Wisconsin Securities Commission disclose that claims adjudication and professional discipline can be housed in the same agency. Moreover, our reviews of financing methods of Maryland's Health Care Arbitration Office and the State Medical Board—fortified by recent data issued by the Inspector General's Office of the Department of Health and Human Services and the Federation of State Medical Boards—suggest that a proposed Medical Practices Review Board can feasibly be financed.
- Judges and court-related personnel evidenced unexpected flexibility in roughly equal divisions of those who favored vesting medical claims disputes in such an expert agency, those opposed to such a change, and those who were neutral and might move toward or away from such a proposal.
- Majorities of 29 experts closely surveyed in a Delphi study judged the proposal to improve efficiency of claims resolution and improve use of medical scientific information; a majority judged the proposal not to be as fair as the current system, although a substantial minority believed an administrative system to be equally or more fair.
- The administrative alternative would save up to 50% of time in dispute resolution from claims filing to compensation and could cost the public significantly less to operate the agency than judicial system costs.
- While political and constitutional questions are yet unsettled, such obstacles, from information gleaned in the states studied, might be overcome, with a few modifications, through amendments to the proposed agency's centerpiece—free, quaranteed legal representation for claimants.

In sum, Georgetown's study staff concludes that the proposed agency could be positioned to address the most important deficiencies resident in the current civil resolution of medical negligence disputes. The workers' compensation model provides a useful template, one that likely would be cost-effective. The provision of paid legal counsel would be a major step forward in patient empowerment at an affordable price level, especially in light of the public costs of running the courts. To be sure, two important issues lay outside our study's boundaries—the fiscal impact of small claims increase heralded by the Harvard study reported midway through the Georgetown effort, and a thorough constitutional analysis of the administrative alternative. Such issues should be answered in service to strategic operational planning of the proposed agency's implementation. However, the information currently available strongly suggests that the administrative alternative could function successfully in a state committed to its goals and a careful demonstration of their implementation. It is possible that a first demonstration would be very successful, in part owing to the failure avoidance activities its sponsors would take in the sunshine of continuous national attention.

Predictions That Must Await a Pilot Test

In support of its proposal, organized medicine made a number of assertions as to the plan's impact, if implemented. These predictions included: (1) an increase in the number of claims filed and of claimants receiving a recovery, since compensation would no longer be limited to the small percentage of patients whose damages were sufficiently large to attract private attorneys; (2) better differentiation between meritorious and nonmeritorious claims; and (3) improved procedural efficiency owing to the expertise of the decision makers. The question remains as to whether these predictions would in fact be realized. They can, however, be posed as high priority research issues and be built into a demonstration project's evaluation package. Such net impact research would help find definitive answers to questions that have long plagued the present system as well.

Similar working hypotheses can be generated for other predictions advanced by organized medicine or any of the authorities enlisted to help Georgetown's study. A strategic plan and a research strategy could be developed for: incentives to attain physician participation in state-sponsored credentialing reviews; efforts to attain physicians' reports of suspected incompetence, impairment, and drug or alcohol dependence among their colleagues; or Medical Practices Review Board staffing patterns to investigate substandard

performance based upon information contained in the various reports mentioned above or as filed by members of the public.

Weaknesses in the Proposed Scheme

While a test of the Medical Practices Review Board would thus be very useful to governments and professional associations, promotion of a research agenda is not the equivalent of saying that the Georgetown review found no defects in and revealed no cautions about organized medicine's model. Discussed at greater length in this article's last section, the Board impliedly sets legal services standards, but the Model Act articulates none. Furthermore, while incentives for participation of the plaintiffs' bar are not ruled out by the Model Act, neither are they addressed in organized medicine's proposal.

Furthermore, restructuring of the reporting relationships between the proposed agency's executive management and its claimant-serving legal staff is absolutely essential to retain health consumers' confidence in the agency's fairness. Legal help should be available initially (prior to claims filing) and continually to claimants, not predicated upon a claims examiner's certificate of merit.

Public sensitization to the agency's availability requires enhanced agency visibility and avoidance of some medical boards' virtual invisibility. If the new institution is dedicated to a more open, more effective system of medical professional regulation, provisions to that end may best be written in the Board's authorizing legislation and not delegated to later rule making.

One important issue may have practical as well as constitutional implications for the proposed Board's fate: the way the Model Act carves out administrative jurisdiction for direct health care providers—physicians, hospitals, nurses, technicians, for example—but leaves indirect health care providers—druggists, pharmaceutical companies, medical device manufacturers, independent testing laboratories, for example—in the current litigation system. The practical issue is a possible "procedural nightmare," identified by judicial members of Georgetown's advisory committee and published in *Courts, Health Science & the Law, 1*, at 48. A mandatory administrative system for adjudication of claims could include "any act incident to or arising out from a health care provider/health care consumer transaction alleged to have led to a patient's injury." Not only would such authority likely avoid fragmentation of dispute resolution, but it could address equal protection of the law issues that some Delphi survey experts identified as potential constitutional challenges to the Model Act.

Other, arguably less urgent, issues could be addressed as well. A public advisory commission should be considered as the proposed Medical Practices Review Board's public reporting authority. And a major, expert-based consensus effort to resolve constitutional issues would prove helpful. But these are adjustments to an institutional design that holds promise to reach a truce between warring factions in the medical liability field. They are refinements of a proposed system that seeks to rationalize medical injury compensation, promote medical professional discipline, empower people who now, by circumstance or choice, are alienated from the legal system. Such adjustments and refinements have been drawn, in part, from the contract writers' comments, summarized above, and five additional mini-studies, described below.

Case Study of a "Best Practices" Workers' Compensation Agency

Summary and Conclusions. Georgetown concludes that a workers' compensation agency model is an apt analogue for organized medicine's proposed Medical Practices Review Board. The plan for such a Board closely parallels the actual structure and function of at least one operating workers' compensation agency, the Wisconsin Division of Workers' Compensation. We conclude from our empirical study of the Wisconsin agency, moreover, that an expert agency can operate fairly, efficiently, and professionally and be perceived to do so. It is possible to avoid the specter of red tape, callous disinterest, perennially starved state budgets, and demoralized state employees attributed by some as the inevitable fate of an administratively adjudicated medical claims system. The similar size, claims-processing capabilities, and budget of the Wisconsin agency suggest that the proposed Medical Practices Review Board could be an organizationally feasible entity.

A case study was conducted in the State of Wisconsin, together with workshop to deliberate its results. Organized medicine's proposal had been discussed, although not documented, as an expert agency in the nature of workers' compensation agencies. Since many states were reconsidering their workers' compensation schemes, Georgetown consulted the literature and expert opinion to find an agency thought to operationalize best bureaucratic practices. Wisconsin was selected, and the Wisconsin Division of Workers' Compensation was studied on-site. To what extent were workers' injury claims fairly and efficiently dealt with? To what extent could the workers' compensation agency be used as a prototype for the Medical Practices Review Board proposed by organized medicine? What implications might stem from the fact that the workers' compensation system is based on no-fault principles while organized medicine's proposal is fault-based? Serendipitously, another model surfaced in Wisconsin—the state's Securities Commission, self-financed and complete with licensure and claims authority under one administrative roof. How, we asked, could the Commission's experience illuminate the claims regulation connection built into the proposed medical practice scheme?

Georgetown's study team, headed by attorney Sandra S. Thurston, read everything available about

the Wisconsin agency and then visited the state. Interviews were conducted with officials inside the Division of Workers' Compensation, counsel representing claimants and employer-defendents, academic evaluators, and former administrative law judges.[11] A draft report was then circulated to the people interviewed, and comments were collected. A formal report was written, herein summarized. That report provided the discussion foundation for Georgetown's workshop on the workers' compensation analogue conducted May 29, 1990.[12]

Because organized medicine sought to link claims adjudication and professional regulation, Georgetown conducted another Wisconsin case study: the Wisconsin Securities Commission. The Commission is an expert agency that adjudicates claims and regulates the professions involved in securities underwriting. How, we asked the Wisconsin Securities Commission, can both functions effectively be linked?

We found in Wisconsin's administrative practice a qualified no-fault system, as discussed below. This is a middle zone between fault and strict no-fault. Worth considering for administrative dispute resolution alternatives, many Wisconsin Workers' Compensation Division features illuminate prospects for the proposed Medical Practices Review Board.

Claimants retain private counsel to represent them in workers' compensation proceedings. Attorneys are compensated through a contingent fee agreement with claimants. Workers' compensation representation frequently is a specialized law practice. Under Wisconsin Administrative Code provision Ind 80.43, claimants' attorneys can receive a maximum fee of 20% of the amount awarded in compensation to their clients. An attorney can charge less than the 20% contingent fee if he or she feels it appropriate; however, the entire 20% fee is routinely approved.

People interviewed for this case study judged there to be no shortage of claimants' representation. A specialized workers' compensation bar has developed. While some informants felt that in some cases the 20% contingent fee was too high, others felt it struck a proper balance between sufficient incentive for lawyer representation, on the one hand, and sufficient realization of injured workers' compensation, on the other.

Approximately 1.9 million people, working for 120,000 insured employers and 150 self-insured employers, are currently protected by the Wisconsin program. This amounts to more than 90% of Wisconsin workers.

Approximately 77,000 claims, 5,400 requests for hearings, and 1,700 actual hearings were processed in 1989. Nearly a 17% increase in claims volume occurred between 1985 and 1989 (Table 2).

Annual Hearings Applications. Most claims are resolved without a hearing. The hearing procedure is described below. Unsatisfied claimants or unresolvable claims may be heard by an administrative law judge (ALJ). Table 3 describes the Division's recent hearings application history.

Table 2

Five-year claims volume in the Wisconsin Workers' Compensation Division, 1985–1989[a]

Year	No. of Workers Compensation Claims Filed
1985	66,235
1986	66,059
1987	68,369
1988	76,917
1989	77,391

[a] Source: Georgetown University Program on Science and Law from data furnished by the Workers Compensation Division, Wisconsin Department of Industry, Labor and Human Relations.

Table 3

Hearings applications requested by claimants by number and by percentage of applications of total claims filed in the Wisconsin Workers' Compensation Division, 1985–1989[a]

Year	No. of Hearings Applications Filed	% of Workers Compensation Claims Filed
1985	5,173	7.81
1986	5,443	8.24
1987	5,561	8.15
1988	5,153	6.70
1989	5,410	6.99

[a] Source: Georgetown University Program on Science and Law from data furnished by the Workers' Compensation Division, Wisconsin Department of Industry, Labor and Human Relations.

Actual Hearings. Approximately two-thirds of claimants settle before their hearing is held. In 1988, 1,676 hearings were held. This is 32.6% of 5,141 applications for hearing filed.

Appeals from Hearings. If a claimant is dissatisfied with a hearing's results, the workers' compensation law in Wisconsin provides for four levels of appeal. The first appeal is filed with the Labor and Industry Review Commission, the second appeal in circuit Court, the third appeal in the Court of Appeals, and the final appeal in the Wisconsin Supreme Court. Each appellate level is empowered to affirm the lower ruling, modify an award, or remand for further proceedings.

The labor and Industry Review Commission is separate from the Workers' Compensation Division and handles workers' compensation appeals, unemployment appeals, and fair employment appeals. The Commission is governed by three commissioners appointed by the Governor for 6-year staggered terms. Commissioners are not necessarily lawyers, and their

salaries are approximately $60,000 a year. They have the authority to affirm, reverse, set aside the findings in whole or in part, or direct the taking of additional evidence. Normally, cases are not remanded to another hearing because the Commission's policy is to encourage complete hearings the first time around.

Table 4 illustrates the policy's impact. Information describing claimants' opinions about the appeals process is not available. Attorneys interviewed judged the process to be fair and evenhanded.

Injury, Qualified No-Fault Mechanisms, and Premium Rates. The Wisconsin workers' compensation law defines an injury as any mental or physical harm due to workplace accidents or disease, including accidental damage to artificial limbs, dental appliances, and teeth.

Because workers' compensation is a "no-fault" system, compensation generally must be paid even if the injury was the employee's fault. In Wisconsin, the no-fault conception is qualified: compensation may be increased by up to 15% if the employer fails to comply with a safety rule or decreased by 15% if an employee fails to comply with a safety rule.

Premium rates for employers are established by the Commissioner of Insurance through the Wisconsin Compensation Rating Bureau. Rates vary, depending on the industry or business type and the kind of work performed. Eight hundred different rate classifications are presently established. Rates in each category depend on previous injury experience. Thus, some incentive exists for employers to maintain a safe workplace. If an employee of an uninsured corporation is injured, the officers of the corporation are personally liable for the payments. It is a misdemeanor for an employer not to secure workers' compensation insurance, which is required by law.

Filing a Claim. Injured workers are encouraged to report an accident or ailment immediately to their supervisor and to seek first aid and medical attention without delay. Notice of an injury or disease should be given to the employer within 30 days.

Claims are barred if not filed within 2 years from the date the employee or his or her dependent knew, or ought to have known, the nature of the injury or disability and its relation to employment. The right to compensation is not barred if the employer knew of the injury upon which that late claim is based. The statute of limitations for these claims is 12 years.

When the employer has notice of employee injury, he or she is then required to report it to the insurance company (or to an internal claims office in self-insurance situations). Simultaneously, an "Employer's First Report of Injury or Disease" must be filed with the Workers' Compensation Division.

If an injured worker misses more than 3 days of work and is found eligible, that worker will receive compensation for lost wages. The employer or insurer is required to send the Workers' Compensation Division a follow-up report within 14 days showing that payment of benefits has begun, or presenting reasons for denial of benefits.

Medical expenses are paid in full, and the worker has the choice of any physician, chiropractor, osteopath, dentist, or podiatrist licensed in the state. Workers have the right to every type of treatment which is "reasonable and necessary to cure" as ordered by the treating doctor.

Injury Classifications. Work-related injuries are allocated into four classifications: temporary total disability; temporary partial disability; permanent partial disability; and permanent total disability. While specific injury classes qualify workers for compensation ranges, they could qualify patients for such ranges and for priority in the dispute resolution process. Organized medicine's scheme has not done so. Neither has its Medical Practices Reform Model Act asserted that vocational rehabilitation is its objective, although such a purpose could be added to it without disrupting the statutory scheme. Both of these workers' compensation features should be examined for their possible transferability.

Claims in Dispute: Settlement Approaches. Sometimes parties disagree about crucial issues—such as whether the injury or disease was related to employment; whether it caused a permanent condition; or the extent of permanent disability. When such disputes arise, the parties have the option to settle the claim or to request a Division of Workers' Compensation hearing. Settlement may occur be means of a stipulation of facts or a compromise agreement.

Using a stipulation, the parties reduce the facts to writing, and the Department may determine an order or award based on the stipulation. The stipulation must set forth in detail the manner of computing the compensation due. It must be accompanied by a report from a physician stating the extent of the disability claimed.

Table 4

Selected characteristics of workers' compensation appeals taken from administrative hearings by claimants by number of decided appeals and affirmation of appeals at subordinate appellate forums, 1989*

Appellate Level	No. of Appeals Decided	No. (%) of Previous Level Decisions Affirmed
Labor & Industry Review Commission	485	364 (76)
Circuit Court	80	57 (71)
Court of Appeals	21	17 (81)
Wisconsin Supreme Court	5	4 (80)

* Source: Wisconsin Labor and Industry Review Commission.

Short of a hearing, a case may also be settled by a compromise agreement. A compromise agreement is considered to be less favorable than a stipulation of fact settlement. For all practical purposes, a case cannot be reopened after 1 year from the date on which an order issues incorporating a compromise agreement.

Stipulations and compromise agreements are subject to the Workers' Compensation Division's review and approval. In disputed cases failing of settlement, a hearing may be held before an Administrative Law Judge. As noted earlier, the proportion of hearings requested is small, and those actually conducted comprise about 2% of claims failed.

The Hearing Process. To apply for a hearing, the employee or his or her attorney must file three copies of a one-page form entitled "Application for Hearing" (WC-7) with either the Madison or Milwaukee Workers' Compensation Division office. If the claim is not settled following application, the Workers' Compensation Division will set a hearing date. Both parties are notified of a hearing date at least 10 days in advance.

Hearings are "semi-judicial" proceedings, with testimony given under oath and subject to cross-examination. Documents and reports are introduced into evidence, and a court reporter transcribes the proceedings.

The ALJ enumerates findings and makes rulings on the ultimate facts in each case based on testimony from all parties, as well as doctors' reports and other pertinent documents and testimony. The plaintiff will usually use the testimony of the treating doctor, whereas the defense may hire its own medical expert(s).

Medical testimony frequently is presented in the form of a written report (to be submitted 15 days before the hearing). Oral testimony is not required.

In addition to medical experts, vocational experts are often utilized to evaluate lost wages. The ALJ may order that the injured worker be examined by a doctor not previously connected with the case.

The Administrative Agency's Budget. The Wisconsin Division of Workers' Compensation's budget was $4,273,962 for Fiscal Year 1989. This budget supported all agency requirements and functions, including 93 full-time personnel; 21 staff attorneys were employed as salaried staff.

The Division's budget is approved and appropriated in procedures consonant with all other state agencies in the Wisconsin budget process. Financial sources are exclusively derived from workers' compensation insurance surcharges and paid into the state's general fund. Expenditures are paid from the general fund and audited as a state function.

Georgetown estimated that the Medical Practices Review Board proposed by organized medicine would cost between $2 million and $7 million to operate annually. The Board and the Wisconsin Workers' Compensation agency would have a comparable staff complement. The proposed Board, however, would include claimant legal representation.

The proposed Board's budget was calculated by varying high and low salary and cost assumptions: a fault-based system entertaining 750 medical injury claims and 250 conduct complaints was used as a constant. Moreover, it was estimated that costs could be paid by a combination of medical negligence premium set-offs, a modest licensure fee surcharge, and users' fees.

The Wisconsin case confirms the general validity of cost estimates related to the Medical Practices Review Board. It also lends confidence to revenue estimates.

The Administrative Law Judge Position: Impact of Fault. ALJs are the key bureaucratic positions proposed for the Medical Practices Review Board, even though they are termed "claims reviewers" and "hearing officers." These are the experts who actualize the term "expert agency." The Board itself is analogous to Wisconsin's Labor and Industry Review Commission. Study staff highlighted pragmatics of the Wisconsin ALJ's position in order to derive implications for administrative resolution of medical malpractice claims.

In Wisconsin, the ALJ is a civil service attorney. When there is an opening for a position, the Division's Administrator interviews four or five applicants.

The starting salary for an attorney without experience is about $28,000; an attorney with about 5 years of experience could expect to earn approximately $40,000 per year. Experienced agency attorneys earn approximately $50,000 per year. Recently, a 20% raise was approved for the ALJs, effective July 1, 1990.

Georgetown staff received mixed commentary about the Wisconsin agency's staff compensation. Some informants thought the salary levels to be attractive, especially in non-metropolitan areas, where housing and the cost of living are not hyperinflated.

Other informants conclude that it is difficult to attract top quality people for the relatively low pay. However, the hours required of professional staff, including ALJs, were thought to be reasonable—40 to 45 hours per week. Legal staff turnover is moderate; the average job tenure is estimated by the Wisconsin agency to be 4.4 years.

Required travel is a drawback cited by several informants who left an ALJ position for private law practice. The Division's 17 ALJs must cover hearings held in 29 cities throughout Wisconsin.

Informants assessed the work of the ALJ to be stressful. On the other hand, the position offers a significant professional growth opportunity—to learn and to see a great variety of cases. It also admits novelty; routine and "burnout" were not reported to be problems.

From Georgetown's staff observations, ALJs appeared to be able to work independently, with over-

sight going to the quality of their decisions rather than the number or nature of their specific rulings. ALJ retention rates mirrored professional personnel generally, with many employed with the Workers' Compensation Division for 4 to 5 years. About 20% of the ALJs are estimated to be full career (long-term) employees.

Going to the matter of bureaucratic indifference to claimants, informants stated that ALJs often develop callousness about the injuries they see most often. This hardened attitude was not seen as necessarily negative. The no-fault system reduced the impact of ALJ attitude upon outcomes. Generally, however, cases likely to be appealed beyond the hearing level involved more profound injuries. In such cases, ALJ attitudes, while objective, were considered to be adequately sensitive.

One comment typified informants' attitudes: "Juries could never do what the ALJs do so expertly and efficiently." There was a general consensus among Wisconsin-based informants, however, that the issues of causation, negligence, and standard of care faced by an ALJ on a Medical Practices Review board could be more complex than those confronted in workers' compensation cases.

Under the proposed Medical Practices Review Board, the fault concept would assure that claims would be more stoutly defended. Linkage of the claims and the discipline systems very likely would intensify that defensiveness. Procedural defenses, however, are limited in organized medicine's Model Act. Thus, delay is less likely to be interposed by parties than is common in lawsuits.

Typical issues in a workers' compensation case are limited to certain fact questions: whether or not the injury is work-related; the date the injury occurred; and the nature and extent of the resulting disability.

Organized medicine's proposal asserts no requirement that an ALJ (hearings officer) be an attorney. Wisconsin informants were questioned about this proposed feature.

Those interviewed felt that a medical claims ALJ should be an attorney, if for no other reason than to add credibility to the position. Credibility can soothe disputes when medical liability issues are very complex and the financial stakes may be high. Some commentators insisted upon a professional degree, a law degree among several options, in ALJ positions. It is a symbol, they believed, of enhanced motivation and commitment, perhaps exceeding public images of the "average civil servant's motivation."

Many Wisconsin informants judged that a trained attorney would feel more comfortable than others in dealing with rules of evidence and administrative procedure. He or she would be better-able to manage the parties' attorneys in controversies before the administrative agency.

Quality Standards in Administrative Work Products. During Georgetown's deliberation of contracted papers assessing organized medicine's proposal to take medical malpractice out of the courts, several Advisory Committee members raised concerns about low quality administrative work products. In Wisconsin, study staff inquired about this matter as applied to the workers' compensation system.

Wisconsin insists upon quality ALJ performances. An ALJ initially is hired for a 1-year probationary period. He or she can be discharged during this period without the usual steps that must be taken to separate a civil service employee from employment. Evaluation is systematic during probation, and close supervision is required.

ALJs receive annual evaluations and qualify for merit pay increases. This cures disincentives posed by time and seniority-based regular increases in grade. The Wisconsin Administrator has developed a point-award system to assess work product quality. Bonuses are calibrated for high quality and exceptional work. All persons interviewed concurred that Wisconsin's ALJs are granted ample independence to reach decisions in cases; they are not under pressure to adhere to a certain philosophy.

Other Administrative Personnel. The Wisconsin Workers' Compensation Division appears to benefit from low personnel turnover and dedicated workers. Interviewees cited many reasons for high personnel retention rates and high employee morale. Some attributed these qualities to a "team spirit" characteristic of Wisconsin public service. Others pointed to a "good government ethic" in that midwestern state, the heritage of La Follette's grassroots populist activism. Others recognized a "German-Polish work ethic" that emphasizes hard work and employee loyalty.

Moreover, public service employee benefits are favorable in Wisconsin. They include group health and life insurance; 2 to 5 weeks paid vacation, depending on seniority; group disability benefits; and pension and retirement programs.

Replication of Wisconsin's employee pool in other states may not be possible. But many of the factors contributing to Wisconsin's success can be transferred to a Medical Practices Review Board. Among them is the bonus-based concept undergirding meritorious performance.

The Use of the Pre-Hearing Conference in Wisconsin. Procedures charted for the proposed Medical Practices Review Board emphasize several mandatory conferences aimed to achieve settlement between the parties at an early time and certainly before a formal hearing. These conferences are accompanied by mandatory settlement offers.

Wisconsin's workers' compensation agency recently abandoned pre-hearing conferences. The experience may prove instructive for an administrative alternative for medical dispute resolution.

Formerly, in Wisconsin, a case automatically went to a pre-hearing conference before a hearing was scheduled. The pre-hearing conference had three

stated purposes: to discuss discovery; to educate the parties about the hearing process; and to encourage settlements.

Wisconsin officials found that the pre-hearing conference did little to encourage settlements or to accomplish the other stated purposes. Positions were entrenched, and the pre-hearing conference appeared to fortify them. In addition, the pre-hearing conferences added to the time and expense of the process.

Wisconsin abolished automatic use of pre-hearing conferences. These conferences are currently used only for complex cases. Currently, only 15% of cases that go to a hearing are scheduled for a pre-hearing conference. Since routine pre-hearing conferences have been abolished, the settlement rate has not changed.

Legal Representation Revisited. Georgetown's staff asked Wisconsin informants about claimants' legal representation in the proposed Medical Practices Review Board. Would a free agency attorney, salaried by the state, be able to effectively advocate claimants' interests in medical negligence adjudication?

The arrangement generally was thought to be feasible. However, concerns surfaced about conflicts of interest, real or apparent, that could occur between claimants' lawyers and their employing agency.

Those interviewed unanimously recommended that claimants' attorneys be stationed in an agency independent of the proposed Medical Practices Review Board. However, they also believed that the private attorney contingency fee provides a useful incentive to dispute resolution. They supported organized medicine's proposal of alternative private counsel when claimants wish to retain outside lawyers. Salaried agency attorneys, several informants agreed, would require incentives to maintain high quality legal representation standards. Wisconsin's ALJ merit award program may provide a template for such an incentive system.

Medical Practices Review Board staff attorneys, Wisconsin informants believed, would be placed in conflict by a Model Act provision that required them to police settlement while advocating compensatory awards. In organized medicine's proposal, legal representation would be terminated if the representing attorney judges his or her client to have rejected a mandatory settlement offer "unreasonably." Such a provision would not be permitted under the Wisconsin Code of Professional Responsibility.

The Discovery Process. Medical reports and records are discoverable by both sides to a dispute. However, depositions are prohibited under Wisconsin Administrative Code Ind 80.12.

Most informants judged deposition prohibition to have increased efficiency. Efficiency gains, they believe, outweighed losses to concepts of procedural fairness. At the same time, repeat players have adjusted to this discovery condition. One claimants' attorney said that one just had to "use (his) wits more" at a hearing if surprised by testimony.

Requirements Imposed by a Hearing. In organized medicine's proposal, a hearing is granted the parties as a matter of right. In Wisconsin, study staff inquired about administrative requirements imposed by hearings.

Hearings in Wisconsin workers' compensation cases often last for one-half day or less. ALJs typically conduct two hearings per day, frequently 4 days per week.

One Wisconsin official estimated that each ALJ spends, on average, 3 hours per case going to hearing. This time estimate includes time devoted to written opinions.

It was generally agreed that the hearing proposed for organized medicine's administrative adjudication agency would be longer than that typical of workers' compensation cases. It would be procedurally complex. Depositions, permitted at the discretion of the hearing examiner, were thought justifiable. In contrast to workers' compensation hearings, the medical dispute would require a larger number of exhibits and documents. Informants agreed that each Medical Practices Review Board ALJ proposal would need a larger support system than is required by an ALJ in a workers' compensation setting.

The Use of Medical/Scientific Evidence and Experts. Experts participating in Georgetown's medical malpractice alternatives Delphi survey believed a proposed administrative agency would use scientific evidence more effectively than the courts. Georgetown staff inquired about this matter in the workers' compensation context.

In Wisconsin, no limit is placed by rule on the number of live witnesses that may testify at a hearing. However, the presiding ALJ may limit witnesses if he or she feels that testimony is repetitive or redundant.

Written medical reports are used to a greater extent than live witnesses, apparently for two reasons: doctors generally do not like to testify as witnesses in these cases and may be unwilling to attend a hearing; and, according to practicing attorneys, the two sides usually agree on the contents of a medical report.

Since a relatively small number of attorneys specialize in workers' compensation, the defense and claims attorneys have developed a relationship characterized by trust and rapport. Their common interest usually is to obtain a fair outcome in the case at hand. Case volume assures attorney remuneration. Stipulations therefore are common. This reduces the need for tortuous or predatory discovery.

Within the hearing context described earlier, two types of experts generally testify in workers' compensation cases. The first are medical experts. They describe the nature and extent of the claimant's injury. The second expert category includes a variety of vocational experts. They testify as to the loss of future earning capacity.

When a Wisconsin workers' compensation agency ALJ faces two partisan experts, the law constrains him or her to select one expert's estimate or the other's (within 5%), and not an intermediate position. Thus, experts are encouraged to offer more plausible, less extreme disability estimates.

Parties' choice of a biased or exaggerating medical expert is thought to be restricted by this ALJ opinion election requirement. The success of this method rests on having ALJs who are experienced and knowledgeable. This places a premium on retention of an experienced ALJ staff.

One former ALJ said that if it appeared that both sides' experts were "out of line," the parties would be so informed and would be encouraged to settle the case. It was also pointed out that "hired gun experts" are quickly identified in this system, and their testimony is weighted with bias. Vocational experts received more criticism than medical experts in Wisconsin interviews. Their testimony could be more easily "bought," and it often appeared to be a waste of time or biased against the injured worker.

Informants representing both plaintiffs and defendants complained about the high cost of experts. In Wisconsin workers' compensation claims, each party pays for its own experts. The ALJ is permitted to call his or her expert if necessary to achieve a better understanding of the issues in a case. However, this is done only rarely.

The proposed Medical Practices Review Board, on the other hand, is designed to freely use neutral and independent experts. The Model Act so provides. And Georgetown's estimates of the Board's financial requirements include significant funds for this purpose, more than $1,000 per case filed, and more than $10,000 per case expected to require a formal hearing.

Fairness to the Parties. This case study discovered a consensus among those interviewed: on balance, they concluded, the injured worker in Wisconsin receives fair compensation in a fair adjudication procedure. Most informants thought that some injuries are overcompensated and that others are undercompensated. In some cases, an injured worker will not receive anywhere near his actual wage losses; but that worker will usually not be forced into poverty either.

Wisconsin officials and observers believed that the workers' compensation system accomplishes its basic purpose. Some observers objected to an antiquated benefit rate. That rate is frozen from the date of injury. Thus, a worker who was injured 30 years ago and then received $90 per week at the top of the benefits scale would now still only receive $90 per week. However, the vocational rehabilitation program can help injured workers learn another line of work.

Criticisms advanced by Wisconsin informants emphasized: "the law was more complex than the process required"; injured workers suffered as the result of damages set according to schedule, rather than by an individualized assessment approach; there was a tendency for smaller cases to be fairly and efficiently resolved and compensated, whereas undue delay and confusion could attend to claims for significant compensation for more profound and complex injuries.

Protection and Improvement of the System's Integrity. The Department of Industry, Labor and Human Relations hosts an advisory council on workers' compensation. Advisory council members are appointed by the Labor and Industry Review Commission. The advisory council includes five labor representatives, five management representatives, three nonvoting representatives of the insurance industry, and the Administrator of the Wisconsin Workers' Compensation Division, who serves as chairperson. Beyond advice, the advisory council reviews legislative proposals to amend the workers' compensation program. Only amendments agreed to by the entire council are submitted to the legislature. Over time, the legislature has developed confidence in this review procedure.

The advisory council buffers the workers' compensation program within the political process. It serves as a counterbalance to special interest groups that lobby for legislative change in their own interest.

Most Wisconsin commentators felt that the council system was good way to pass amending legislation. Advisory council hearings are open to the public. One informant observed that it is often difficult to get injured workers actively involved in the advisory council's hearing process. Self-interest is limited. Amendments would usually not retroactively benefit injured workers, and compensation levels are not an issue for uninjured workers.

The proposed Medical Practices Review Board contains no mechanism similar to Wisconsin's advisory council. It is believed that the Board's credibility would be enhanced by an advisory council widely representative of health policy, provider, and consumer interests.

Administrative Appeal and Judicial Review. A case must be appealed within 21 days of an ALJ's decision following a workers' compensation claims hearing. The Labor and Industry Review Commission has 20 days in which to answer the appeal.

The Commission's attorney examines the actual record of each appealed case. The examination includes a summary of testimony or other evidence presented at the hearing. The summary is prepared by the ALJ who heard the case.

The file is then routed to one of the commissioners who will briefly write his or her inclination concerning the case, usually in one or two lines. The file is then routed back to one of the 12 Commission reviewed attorneys, three or four of whom review workers' compensation appeals exclusively.

The reviewing attorney then writes a longer recommendation to affirm, reverse, modify, or remand the workers' compensation ALJ's decision. The review attorney typically reviews one or two cases per day. The attorneys and commissioners meet regularly to

discuss the cases and come to a final decision. Normally, the commissioners accept the review attorney's recommendations.

Since the review is entirely on the record, the reviewing attorneys do not have the opportunity to see the witnesses' manner and demeanor. In contrast to judicial proceedings. Review Commission attorneys are permitted to consult the workers' compensation agency ALJ. They may inquire about the witnesses' demeanor and credibility.

Review Commission attorneys interviewed for this study were asked about ALJ attitudes in the lower agency. Were the ALJs defensive about their decisions? Would the ALJs share with the reviewing attorneys a distinctly biased view?

Review Commission attorneys answered that the ALJs tended to be advocates of their decisions; however, gains were realized in an unclear case from consultations with the ALJ. If a conversation with the ALJ takes place, its substance is entered into the reviewing attorney's record, and it is thus preserved for subsequent appeals proceedings.

Wisconsin observers agreed that Review Commission attorneys render a careful and conscientious examination of appealed cases. Reviewing attorneys are not afraid to reverse an ALJ when warranted. A few informants believed that Review Commission attorneys may spend more time per file than spent by ALJs.

During the Georgetown case study, the Labor and Industry Review Commission had a case backlog and sought approval for additional legal help. The reviewing attorneys are able to rotate among cases appealed from the divisions of unemployment, workers' compensation, and fair employment.

An appeal of the Review Commission's decision may be made to the Circuit Court, but findings of fact made by the Commission, in the absence of fraud, shall be deemed conclusive if substantiated by credible and substantive evidence. About 16% of the cases that reach the Commissioner are appealed to Circuit Court. From the Circuit Court, an appeal may be made to the Court of Appeals and eventually to the Supreme Court.

In contrast to organized medicine's proposed appeals structure, the Wisconsin review of administrative decisions encompasses substantive and procedural matters. The appeals process of Wisconsin workers' compensation decisions seemed to be independent and thorough. Georgetown staff were impressed by the Review Commission's independence. It seemed significant that the appeals level was independent from the operating workers' compensation agency. Appellate personnel exist separately and independently in the state's organizational structure. With a separate reporting structure from workers' compensation ALJs, Review Commission and judicial personnel had no particular allegiance to the operating agency. This arrangement seems, in part, to account for the credibility enjoyed by Wisconsin's workers' compensation system.

Conclusion. Georgetown's case study of "best agency practices" in the workers' compensation system permits a few conclusions and implications.

Historically, the need for workers' injury compensation legislation crystallized at the turn of the 20th century. Relationships between large population groups—employees and employers—had become severely strained. Peace in the workplace was sought amid public awareness that judicial remedies available to injured workers were spare, litigation costly, and employer defenses nearly impenetrable. Unrest was growing. Industrial development was handicapped.

At the turn of the 21st century, similar observations are made with respect to relationships between two large population groups—health care consumers and health care providers. Health care gobbles up a lion's share of the gross national product (11%) while the nation attempts to compete globally in a postindustrial, service-oriented economy.

Health-related litigation apparently burdens the society and the health care professions, pushing up costs through insurance policies and defensive medical practices. No one knows the toll levied by iatrogenic illness from the injured plaintiffs' collective perspective. Medical injury, by all reliable reports, is common, but only a small proportion of those injured appear to have access to the legal system. An even smaller proportion is compensated.

In the future, many justice system planners believe, the administration of justice will be diversified. Administrative adjudication could be one important foundation of such diversification.

The workers' compensation program provides an appropriate and informative foundation upon which a fault-based administrative alternative for medical negligence may be considered. Organized medicine correctly adopted it as a precursor and analogue. That adoption is not without its problems, however.

The principal conceptual difficulty is adaptation of organized medicine's fault-based system to administrative adjudication rooted in no-fault conceptions. We have observed that the fault concept is an important link between medical claims and medical professional regulation, a social policy necessary for the continued integrity of the health care system, but fault-based systems galvanize resistance and stigma.

One way out of this conceptual knot may be the use of qualified fault and qualified no-fault concepts. The means to bridge these concepts may be scheduled compensation awards keyed to authoritative health care practice guidelines. The prospects seem to outweigh the obstacles.

Our studies of Wisconsin indicate that it is possible to establish an Article I adjudication system characterized by relatively high degrees of

- fairness
- efficiency

- prompt, arguably adequate compensation for the injured
- retention of a high level of professionalism and experience in the administrative bureaucracy
- a high settlement rate
- a fair review process

All of these attributes are related to the goals of organized medicine's proposal.

Workers' compensation agencies have been in place for 80 years and therefore have eight decades of experience upon which to draw. Organized medicine's proposal is yet to be tested. The Wisconsin workers' compensation agency experience lends confidence to the prospective operation of a fair and expert medical dispute resolution agency.

Our study from Wisconsin indicated that adequate funding is crucial to the success of a workers' compensation system and will also be crucial to the success of organized medicine's proposal, especially in the start-up years, when factors such as the number of expected claims will be uncertain. There was unanimous agreement throughout our study of an administrative analogue that medical malpractice cases are more complex and will require a greater amount of expertise and a greater amount of resources than workers' compensation cases.

Opinion Surveys of Judges and Court-Related Personnel[37]

In addition to the expert surveys described here, researchers at Georgetown also conducted surveys of judges and other court-related personnel to determine their views as to the desirability of diverting medical malpractice cases to an administrative agency.

First, we conducted a survey of 61 judges and 22 other participants at the Conference on AIDS and the Courts (Miami, Florida) and at the Second Midwestern Conference on Court Management (Milwaukee, Wisconsin), both held in April 1989. Tables 5 to 7 present the aggregate responses. The results showed that roughly one-quarter favored such a diversion (19 of 83 total participants). Approximately the same number (17 participants) were neutral on the question, and slightly more believed that the idea was undesirable (24 participants).

Table 5

Frequency and percentage distribution of opinions about medical malpractice diversion to administrative adjudication yielded by participants in the Conference on AIDS and the Courts, and the 2nd Midwestern Conference on Court Management, April 1989 (*N* = 85)

Response	Frequency	%
Very desirable	20	23.5
Neutral	17	20.0
Very undesirable	24	28.2
No opinion	9	10.6
Different view	6	7.1
No answer	9	10.6
Total	85	100.0

Table 6

Comparison of judges' and non-judges' opinions about medical malpractice diversion to administration adjudication yielded by participants in the Conference on AIDS and the Courts, and the 2nd Midwestern Conference on Court Management, April 1989 (*N* = 83)[a]

Response	Judge		Non-Judge	
	No	%	No	%
Very desirable	13	21.3	6	27.3
Neutral	14	23.0	3	13.6
Very undesirable	19	31.1	5	22.7
No opinion	5	8.2	3	13.6
Different view	6	9.8	0	0.0
No answer	4	6.6	5	22.7
Total	61	100	22	99.9[b]

[a] Two persons failed to specify occupation and were dropped from the sample

[b] Due to rounding.

Table 7

Frequency distribution comparison of various types of judges' opinions about medical malpractice diversion to administrative adjudication yielded by participants in the Conference on AIDS and the Courts, and the 2nd Midwestern Conference on Court Management, April 1989 (*N* = 61)

Response	Type of Court Represented by Judicial Survey Participants				
	General Trial Court (*N* = 32)	Appeals Court (*N* = 3)	Special Jurisdiction Court (*N* = 20)	Other Court (*N* = 6)	Total (*N* = 61)
Very desirable	9	0	3	1	13
Neutral	7	1	5	1	14
Very undesirable	8	1	7	3	19
No opinion	1	1	2	1	5
Different view	5	0	1	0	6
No answer	2	0	2	0	4
% of judges' subsample	52.5	4.9	32.8	9.8	100.0

In a second survey, a written questionnaire was sent to recipients of grants from the State Justice Institute seeking their assessment. Of the 81 respondents, 33% favored the idea, 15% were neutral, and 36% were unfavorable, with the balance expressing no opinion or providing no answer. Tables 8 to 10 present the aggregate responses.

Moreover, Georgetown University's Editorial Associates comprised another sample. Two hundred lawyers, judges, and scientists responded to the following question:

> Medical malpractice is one lawsuit frequently litigated in State court. To what extent do you regard as desirable removal of this type of action from the courts to an administrative dispute resolution system modeled along the lines of a workers' compensation agency with attorney representation of claimants' provision for attorneys' fees?

In this sample of 200 Editorial Associates, 56% found the removal of medical malpractice suits from the courts into some form of alternative dispute resolution mechanism to be very desirable or desirable.

The distribution occurred about equally among the occupational reference groups comprising the survey sample (Table 11). Thirty of the 200 Editorial Associates (15%) had received degrees in more than

Table 8

Frequency and percentage distributions of opinions about medical malpractice diversion to administrative adjudication yielded by a sample of State Justice Institute grantees responding to a mailed pencil/paper questionnaire, November 1989 to January 1990 (*N* = 81)

Response	Frequency	%
Very desirable	10	12.3
Somewhat desirable	17	21.0
Neutral	12	14.8
Undesirable	19	23.5
Very undesirable	10	12.3
No opinion	10	12.3
No answer	3	3.7
Total	81	99.9[a]

[a] Due to rounding.

Table 9

Frequency distribution by court-related role re: opinions about medical malpractice diversion to administrative adjudication yielded by a sample of State Justice Institute grantees responding to a mailed pencil/paper questionnaire, November 1989 to January 1990 (*N* = 81)

Response	Type of Role Represented by SJI Grantee Survey Participants					
	Court Administrator	Commentator[a]	Judge (Appellate)	Lawyer	Other	Total
Very desirable	3	2	2	2	1	10
Desirable	4	5	5	3	0	17
Neutral	5	2	1	2	2	12
Undesirable	8	4	4	2	1	19
Very undesirable	4	3	2	1	0	10
No opinion	4	4	0	1	1	10
No answer	0	0	2	1	0	3
Total	28	20	16	12	5	81

[a] Commentator = academic or foundation or research institute personnel.

Table 10

Percentage distribution of court-related role re: medical malpractice diversion to administrative adjudication yielded by a sample of State Justice Institute grantees responding to a mailed pencil/paper questionnaire, November 1989 to January 1990 (*N* = 81)

Response[a]	Type of Role Represented by SJI Grantee Survey Participants					
	Court Administrator (*N* = 28)	Commentator[b] (*N* = 20)	Judge (Appellate) (*N* = 16)	Lawyer (*N* = 12)	Other (*N* = 6)	Total (*N* = 81)
Favorable	25.0	35.0	43.8	41.7	20.0	33.3
Neutral	17.9	10.0	6.3	16.7	40.0	14.8
Unfavorable	42.9	35.0	37.5	25.0	0.0	35.8
No opinion	14.3	20.0	0.0	8.3	20.0	12.3
No answer	0.0	0.0	12.5	8.3	0.0	3.7
Total	100.1	100.0	100.1	100.0	100.0	99.9

[a] Favorable = Very desirable + Desirable; Unfavorable = Undesirable + Very undesirable.
[b] Commentator = academic or foundation or research institute personnel.

Table 11

Occupations of Editorial Associates responding to survey

Occupation	No.	%
General practice lawyers	57	28.5
Civil defense lawyers	31	15.5
Civil plaintiffs' lawyers	15	7.5
Patent lawyers	11	5.5
Appellate lawyers	2	1.0
Environmental lawyers	7	3.5
Government lawyers	7	3.5
Other specialized lawyers[a]	15	7.5
General trial judges	1	0.5
Law professors	10	5.0
Physicians	15	7.5
Health scientists	17	8.5
Others: administrative/policy roles	12	6.0
Total	200	100.0

[a] Specialized lawyers include attorneys specializing in health, intellectual property, and real estate law, several serving as counsel to hospitals, businesses, and research organizations.

one discipline. The following combinations were reported: M.D./J.D. (11); J.D./Ph.D. (10); J.D./M.A. (4); J.D./L.L.M./M.A. (health law) (1); J.D./M.A./C.P.A. (1); J.D./M.B.A./M.S. (1); J.D./M.S. (engineering) (1); and J.D./M.P.H. (1).

While these surveys were not designed to provide statistically valid measures of judicial opinion, they do suggest a receptivity to the basic theory informing organized medicine's proposal from a group that might be expected to be more strongly supportive of the current court system. There appears to be significant openness to the concept, as revealed by the large number of respondents who were "neutral" on the issue. If the utility of the administrative approach could be established by empirically sound research, considerable additional support for the administrative approach could be forthcoming.

From the patient's perspective, organized medicine's proposal has not been subjected to representative samples in public opinion polls. There are some suggestions from the literature that recovered compensation under any alternative may be smaller than awards from lawsuits surviving through trial,[18] a period typically lasting from 2 to 6 years. The trade-off appears to be guaranteed access to a claims system and a legal system that Georgetown calculates could result in compensation in as little as half the time of the current system. The stress experienced by claimants may be substantially lower, although empirical data on this are lacking. It appears that the ingredients for a meaningful trade-off, however, are provided by organized medicine's proposal.

How this trade-off may be viewed by health care consumers is not clear, but it may depend upon how the public is approached about it. If an expert agency alternative were introduced to promote consumers' interests in health care quality, and not as a hedge against large jury verdicts, the agency context may not be offensive. The public has expressed misgivings about the health care system but generally appears to be comfortable about patient-doctor relationships. In spite of anecdotal commentary to the contrary in the press, recent surveys disclose the overwhelming preponderance of the public to regard relationships with physicians as satisfactory and personal experience with health care as adequate. Nevertheless, concern about health care system continuity and worst case occurrence coverage worry Americans far more than health care consumers in other industrialized nations. These findings were recently reported by the Louis J. Harris Organization in conjunction with the Harvard School of Public Health and the Institute for the Future.[19]

At the same time, the Gallup Organization, in a poll conducted for the American Society of Cataract and Refractive Surgery (not a member of the Medical Liability Project sponsoring organized medicine's Model Act), found in a nationwide survey, reported in January 1990, that "6/7 of the respondents said they currently maintain a relationship with a physician. 68% of such respondents were very satisfied and 26% of the respondents were satisfied with the quality of care they received from their physicians."[20]

A cost-effective alternative to improved medical practices, then, may strike a responsive chord among the public. Organized medicine has created a design for a new institution that could yield such expectations.

Delphi Survey of Medical Malpractice Experts

The fourth study performed was a twice-iterated survey of 29 experts from a variety of backgrounds, including plaintiffs' attorneys, defense attorneys, malpractice insurers, hospital administrators, physicians, and academic personnel from a variety of fields including law, health policy, and economics.[21] This is a so-called Delphi study, because it attempts to portray agreements and disagreements leading to predictions or scenarios.[22] This tool is used frequently to concentrate expert opinion under conditions of high uncertainty. It is a policy research tool that has gained respect in the technological forecasting field. We used a modified approach and highlighted agreements and disagreements about organized medicine's proposal, but dispensed with scenarios that could only be generated by simultaneous computer modeling with the experts meeting together or networked on-line, features not funded by the present study.

We attempted to enlist experts representing different professions that played roles in adjudicating cases or evaluating the workings of the malpractice system; an obvious challenge was to obtain a sufficient breadth of coverage. The experts were nominated by our project's national advisory committee, and then selected by the researchers from among a roster of nearly 100 candidates. The first 35 were chosen

blindly, in lottery fashion, from sector batches so as to assure sector balance. Fifteen additional persons were selected as a second queue of replacements in the same manner. Twenty-nine persons completed both phases of this mini-study and were paid a modest honorarium for their participation. Our informant sample objective was 30 experts.

Unlike this project's first mini-study, where the commissioned authors were free to structure their analyses according to their own sense of what was important, this survey was more structured. We developed a series of questions focusing upon key attributes of organized medicine's proposal and sought the experts' reactions as to the proposal's likely impact. These key issues included such questions as the proposal's constitutionality, feasibility, potential for improving the efficiency of the current system, and overall fairness. The questions also aimed at focused assessment of specific features of the proposal, such as its use of blind settlement offers, and the specific substantive law changes proposed by the Model Act's sponsors.

The survey was conducted in two phases. The first phase required the experts to complete a questionnaire. The second phase consisted of a personal interview conducted by the members of our research staff. All interviews were conducted by telephone from a uniform schedule. In the paper-and-pencil survey phase, participants were provided with a summary of the proposal, the Model Act, and explanatory materials for completing the questionnaire. The primary findings are summarized here. The second phase, the interview, supplied questions ahead of an appointed telephone call. Also supplied was a summary of the first phase's results, and participants were asked to comment.

A summary of relevant professions included are: attorneys (7); physicians (4); academics (7); insurers (2); health maintenance organization representatives (1); consumer advocates (3); governmental officials (4); and journalists (1). Within a particular area, efforts were made to canvass a variety of viewpoints. For example, in the attorneys category, we surveyed two plaintiffs' attorneys, three defense counsel, one corporate attorney, and one tort reform expert.

The majority of the respondents concluded that a test implementation of the Model Act is warranted. Perhaps the most important issue was the experts' views as to whether the administrative alternative represented an improvement over the current system in terms of overall fairness and efficiency. There are, of course, definitional questions with respect to both goals—fairness or efficiency could be measured according to a number of different perspectives and parameters. We did not attempt a definition of either term.

We urge caution upon the reader with respect to results: with only 29 expert participants, percentage representation, the form in which this information is presented, cannot possibly be representative or statistically significant given the sample bias inherent in the mini-study. Nonetheless, the aggregated opinions, as well as matters avoided, provide some illumination about organized medicine's proposal. Moreover, the research staff believes the participants to be highly qualified in the medical negligence field. We experienced an extraordinary willingness to go beyond requirements to satisfy the survey's requests.

While a substantial minority (approximately 40%) stated that the administrative alternative would likely enhance the fairness of the claims resolution process, the majority (approximately 60%) opined that it would result in little or no improvement in fairness. The reasons given to explain the majority's skepticism varied. Some experts anticipated that the system would place an unfair emotional and financial stress on the claimants, perhaps owing to the lack of a true adversarial representative working on their behalf. Others felt that the procedures established by the proposal favored physicians or questioned the fairness of allowing medical representation on the Board.

With respect to efficiency considerations, the weight of opinion favored the proposal. A clear majority (approximately 60%) stated that the proposed system would likely result in a moderate to great improvement as compared with the current litigation system; 40% anticipated little or no efficiency gains. Among the majority, efficiency gains were expected based upon the speed of resolution and the quality of decision making. The initial steps of filing a claim under the proposed system would be much easier than the filing of a formal suit under the present system. The experts suggested that the most dramatic improvements would occur in two categories of cases: (1) the routine administration of smaller claims which the system currently does not handle well; and (2) handling medical technical disputes in which the Board's expertise would be useful. Skeptics pointed to the inevitable pitfalls of any bureaucratic system. In the absence of an operational definition of "efficiency," however, it appeared to the research staff that most majority respondents designated access and ease of access as their efficiency indicator in the paper-and-pencil survey.

Perhaps somewhat surprisingly, there were no major differences in terms of the occupational or employment settings that appeared to influence opinion on these issues, other than the expected fact that plaintiffs' representatives were uniformly negative. Of course, within any occupational category, there were only a small number of experts; the largest group, for example, was academics, of which seven were included in the survey. A few comments on reactions related to expert status are worth noting.

The physicians surveyed seemed wary of expecting too much from the proposed adjudication system. They tended to give the proposal high marks with respect to efficiency considerations and more compensation delivered to actually injured patients. They doubted that the claims or professional regulatory

regimes would decrease the incidence of medical negligence. They appeared to question whether the administrative forum would reduce the stress associated with malpractice litigation.

Plaintiffs' attorneys saw no advantages and instead highlighted constitutional problems. Plaintiffs' attorneys seemed less likely than all others to weigh the issues overall.

The survey's academics expressed reservations over the proposed adjudication system's potential effectiveness, but seemed eager to evaluate outcomes of an actual demonstration effort. This group attributed the following strengths to the proposal: simplified claims management; potential for fast and efficient small claims settlement; improved handling of technically complex cases; and a cap on awards. They also regarded personnel as critical to the proposed expert agency's success; they were suspicious about state government's ability to attract and retain high quality personnel, and raised additional questions such as the legitimacy of the Board's make-up, specifically, the number of members from the medical profession. They seemed unaware that, currently, in every state, the medical profession occupies most (all in some states) of the state medical boards' authorized seats and that the administrative proposal would be governed by a lay majority upon the Medical Practices Review Board.

The experts generally believed that organized medicine's proposal offered a potentially successful forum in which the facts comprising evidence of injury and fault could be appropriately presented and examined. Sixty-two percent of the respondents anticipated an improvement in the use of medical and scientific evidence in an administrative forum when contrasted with the court system. The reasons for such trust are not clear from first phase survey results, but the follow-up interviews suggested that the improvement was attributed to the expertise of the claims reviewers and hearing examiners, who were likely to be a more receptive, objective, and competent audience for presentations of such evidence. Several respondents qualified their support, noting that the key issue as to whether this benefit would be realized depended upon recruiting high quality reviewers and hearing examiners.

A similar opinion favoring the administrative adjudication proposal was observed with respect to cost of resolving these claims. A majority of approximately 60% predicted that there would be a moderate to great reduction in costs to physicians. These reductions would translate into lower medical malpractice insurance premiums. A similar majority anticipated a reduction in costs to the claimants, owing in part to reduced need for private counsel. Sixty-nine percent of the respondents felt that there would also be reductions to liability insurance companies, but the magnitude and utilization of such savings were not estimated. Most expected that, overall, there would be little or no cost savings, however, because of the likely increase in the number of claims.

In assessing the proposal's ability to improve the quality of health care, opinion split evenly. Forty-eight percent of the respondents predicted little or no improvement; 45% anticipated some or great improvement, with the balance expressing no opinion. It is not clear whether the administrative proposal's linkage between claims and discipline was considered or whether the experts thought that medical negligence was simply a minor factor in achieving quality care. In a related finding, a large majority (72%) opined that implementation of the plan would cause little or no reduction in the incidence of medical negligence. They may have equated low medical negligence with high quality of care. On the other hand, the U.S. Congress Office of Technology Assessment has determined that medical negligence is a weak predictor of health care quality, with much more weight given to medical professional discipline, a proposal feature that the Delphi experts failed to emphasize.[43]

Most did agree that the proposal would spur claims frequency since many small claims would be asserted by claimants who would not or could not otherwise enter the litigation process. Sixty-five percent predicted moderate or great increase in claims frequency. It was suggested that some of these additional claims would be nonmeritorious claims in which the patient was angry with the doctor for some reason. Given the ease of filing, many of these claims, which are currently screened out of the system by plaintiffs' attorneys, were predicted to be filed. Recent findings by the U.S. General Accounting Office's study of Michigan's voluntary medical arbitration system, however, cast doubt upon such an automatic result.[44] If case filing increases occur, it is a matter for research to determine the stimulus for such as increase in the absence of private lawyer incentives.

The respondents were also asked to give their assessment of specific features of the model statute. The experts were sharply divided regarding most features. For example, slightly over half favored the following provisions moderately or strongly: (1) requiring settlement offers to be made at both the initial prehearing conference and again at the final prehearing; (2) placing caps on non-economic damages; (3) changing the standard of causation to one of pure comparative negligence; and (4) limiting judicial review of the Board's actions to procedural issues only. The largest "approval" rating, at about 70%, was given to the use of collateral payments to reduce damages and periodic payments of any award of future damages to a claimant.

Concern was expressed about the proposal's chances of enactment, although the Delphi study was conducted in early 1990, just as the federal government's initiatives in medical tort reform were being readied and before the Harvard Study of New York was released. Two respondents believed that a legis-

lature would enact the plan in its present form. The balance of those answering were evenly split: one-half (13) refused to speculate as to its legislative prospects owing to a lack of familiarity with the local political process; the other half thought political alliances would result in the proposal's rejection by the legislature in their respective states. Thus, some Delphi experts worried that regardless of the proposal's merits, it could fail on purely political grounds.

The survey indicated the experts' beliefs that the fault-based administrative proposal could face significant constitutional challenges if enacted in its present form, but that the proposal would survive constitutional tests. The proposal's primary feature is to abolish civil court jurisdiction in medical malpractice cases in favor of an administrative agency that would resolve claims without a jury. Nineteen experts (65%) anticipated that a constitutional challenge based upon the right to jury trial would be launched against the proposal; many experts also anticipated due process (11 experts) and equal protection challenges (10 experts).

While we do not focus on the likely outcome of the specific challenges, most experts opined that the equal protection and the due process problems could be surmounted if a robust public record of public benefits were made during legislative enactment of the model bill or its successor. The experts were less confident that the right to jury trial argument would be rejected by a reviewing court, but many left the matter unresolved, preferring to suggest that trades for the jury system must be clearly advantageous to a given state's health consumers.

The experts had no consensus on the ideal environment for testing the plan. Several believed that a state with high costs and a high volume of cases would be best suited, while others suggested a small state with low case volume. The experts nominated 25 specific states as possible sites for implementation.

We also asked the respondents what improvements or changes they would make in the proposal. Nineteen of 29 respondents offered changes. The most commonly recommended change centered on the issue of judicial review. Five experts voiced concerns about the limitations that the model statute placed on appellate review. But only one additional respondent insisted that the right to trial be preserved. In response to the question of whether a change to provide a trial de novo was preferable, response was split. Twelve respondents claimed that such an amendment would increase their support; 14 experts said it would not. Five experts said that the availability of a trial de novo would eliminate their support for the proposal, apparently on the grounds that it would undercut the basic premise of the proposal as a replacement for the current system. Four experts noted that such a change would almost certainly make the experiment politically more attractive.

The workers' compensation system has been cited as an organizational analogue for the administrative alternative. During the follow-up interview, the experts were asked what, if any, aspects of the workers' compensation system were transferable. The operational advantage most often cited was the enhanced efficiency of the administrative system. This efficiency was attributed to a combination of development of expertise within the administrative system and abolition of the jury. Other perceived advantages included lower costs for adjudication and consistency of decisions and awards. Operational disadvantages of the workers' compensation system included the increasing "lawyerization" of the compensation process, but no workers' compensation agency offers free legal assistance to its claimants, a unique feature of the administrative alternative. Several respondents noted that the analogy between workers' compensation systems and the proposed administrative system was imperfect, but Georgetown's examination of a workers' compensation agency disclosed in actual design and operation a much better fit than these few experts expected. The removal of fault from workers' compensation cases, three experts suggested, greatly facilitated the function of the compensation board; the Board's task in applying a fault-based standard would be much more difficult. Many workers' compensation agencies, however, operate a limited no-fault system: fault concepts are applied and employer penalties assessed in workplaces failing to prevent recurrent injuries. It may be that some medical injuries are more complex, as a few experts suggested: in compensation cases, the worker may be healthy prior to the injury, whereas in medical liability, the identification of damage and fault is complicated by pre-malpractice illnesses or injury.

The respondents were also asked to compare the desirability of implementing organized medicine's proposal with a lengthy list of other proposed tort reform options. The only alternative receiving overall favorable scores was pretrial screening panels.

In general, the administrative alternative was viewed in more favorable light than the current civil justice system. In general, the experts supported its demonstration. Many of their comments appear to offer ideas to assist a strategic plan for its implementation.

Administrative Alternative Time and Cost Compared with the Civil Justice System

For all the heated talk about the subject, efficiency is a most imprecise concept when it comes to resolving claims between patients and doctors. Two proxy variables for efficient dispute resolution, from many potentially available, are the time required and the costs encumbered.

Adjudication Time. The literature castigates the judicial system generally on time imposed. Justice delayed has been described in the most searing criticisms as justice denied. The U.S. General Accounting Office (GAO) has promulgated time estimates for medical malpractice dispute resolution.[45] Organized medicine's Model Act establishes maximum time horizons for

Table 12

Minimum and maximum time requirements of claims adjudication estimated for a proposed expert agency in medical tort cases[a]

Sequence of Adjudication Process Steps	Elapsed Time Required	
	Best Case Estimate	Worst Case Estimate
Claim filed	10 days[e]	10 days[e]
Claims review conducted	60 days[e]	180 days[b]
Settlement meeting held	n/a[c]	2 days
Single board member review conducted	n/a	30 days
New claims review conducted	n/a	10 days
Peer review conducted	10 days	60 days
Second peer review conducted	n/a	60 days
Attorney assigned	1 day	3 days
Claim to hearing examiner	60 days[e]	60 days
Pre-hearing conference held	1 day	2 days
Discovery completed	90 days	360 days
Pre-hearing conference held	1 day	2 days
Hearing arguments submitted	10 days	10 days
Oral hearing held	n/a	35 days
Findings of fact presented	5 days	10 days
Hearing examiner request expert	n/a	60 days
Expert's opinion	n/a	60 days
Hearing held	n/a	45 days
Findings of fact presented	n/a	10 days
Examiner's judgment	90 days[e]	90 days[e]
Medical board judgment (petition for review)	30 days[e]	30 days[e]
Review panel appointed	n/a	15 days
Briefs filed	n/a	90 days
Oral argument held	n/a	15 days
Opinion of review issued	n/a	30 days
File appeal[d]	n/a	30 days
Intermediate appellate	n/a	60 days
Highest appellate	n/a	180 days
	368 days (1 year)	1,549 days (4 years, 3 months)

[a] Georgetown estimates formulated through staff consultation and based primarily on litigation experience in the State of Virginia. Adjudication time may vary from state to state. The Georgetown estimates are provided merely as a guideline. Note: Georgetown utilized "conservative" time estimates. That is, maximum time was allocated to each adjudicated step in order to accumulate the longest elapsed times from filing to final case disposition.

[e] Elapsed time maximum prescribed by model statute utilized as Georgetown's assumption.

[b] Model statute permits administrative discretion to set elapsed time limits by order on a case-by-case basis. Georgetown assumed elapsed time limit orders (claim amended twice, see footnote c) in this process step.

[c] Elapsed time omitted based on the assumption that merit of the claim is uncontested and that this step is mooted by expert personnel in light of claimant's clear and convincing evidence.

[d] Elapsed time for litigation studies generally does not include appeal.

case processing. An action-forcing mechanism in the nature of early established trial dates, these deadlines permit organization of the events, decisions, actions, and process loops in elapsed time estimates. These time estimates can be arrayed according to case complexity.[16] Table 12 presents maximum and minimum time requirements estimated by this study's staff as extrapolated from the Model Act's provisions.[17]

Georgetown researchers generated two case complexity scenarios and "ran them through" the proposed administrative system. The "simple" case scenario assumed the claimant alleged a misread x-ray of a potential bone fracture. It is termed "Best Case Estimate" in Table 12. The "complex and profound" case assumed the claimant alleged a severe infant birth injury. It is termed "Worst Case Estimate" in Table 12.

Applying the statutory scheme, we calculated that the "simple" case would require a maximum of a little over 1 year from filing to resolution, assuming all steps of the administrative process were taken as prescribed, with the exception of judicial review for alleged procedural irregularities. The "complex and profound" case would require a maximum of 51 months using the same calculation assumptions.

By arraying these estimates against their closest judicial time estimates published by GAO, it is possible to roughly compare the time requirements of proposed administrative and actual judicial dispute resolution systems, respectively. Table 13 presents this information.

In observing that it would likely take about half the time to resolve a "simple" case, and save about a year in the resolution of a "complex and profound" case, no guarantees as to actual elapsed time can be made. One recent study of North Carolina federal court-annexed civil injury arbitration concluded that time is not saved, but money is saved.[18] Clearly, only evaluated experience can measure such outcomes. The administrative proposal's virtue is its prescribed time schedule; administrative law judges could override these prescriptions, but only for cause. The statutory attitude would urge conclusion while permitting case-by-case flexibility.

Georgetown's estimates assumed settlement rates in calculating time horizons for the proposed administrative agency.[19] In general, we assumed that one-third settled at the first mandatory settlement offering opportunity, one-third settled at the first such opportunity after a finding of claims merit, and the remainder dwindled steadily through settlement until 10% of 750 claims filed annually proceeded through a hearing and administrative review of hearing results. This is a more conservative assumption than Virginia's set-

Table 13

Comparison of elapsed dispute resolution time estimates for administrative, fault-based system under organized medicine's Model Act and U.S. General Accounting Office (GAO) estimates of time required for medical negligence actions in the court system

Type of Dispute Resolution and Source of Data	"Complex/ Expensive Case" Elapsed Time[a] (months)	"Typical Case" Elapsed Time[b] (months)
Medical malpractice litigation in the court system documented by the GAO[c]	64.9	25.1
Medical malpractice adjudication estimated by Georgetown from a step-flow analysis of organized medicine's Model Act[d]	51.0	12.1

[a] "Complex/Expensive Case" as applied to the GAO study refers to claims of $1 million or more closed in 1984. "Complex/ Expensive Case" as applied to the Georgetown analysis refers to claims which take the maximum amount of time to be processed by the administrative adjudication system. Note that these definitions carry slightly different meanings. However these constructs are as comparable as Georgetown could find.

[b] "Typical Case" as applied to the GAO system refers to the case with the average disposition time for all claims closed in 1984. "Typical Case" in the Georgetown system is estimated by assuming a more efficient processing of a claim from filing to final resolution, involving the least amount of time necessary for this to occur. Again, these definitions are not exact for each study but allow these two studies to be more comparable.

[c] The figures for disposition time found in this study are averages calculated for different payment ranges. These disposition times are estimates from the time of filing to the time of settlement or final judgment. See *Medical Malpractice, Characteristics of Claims Closed in 1984* (GAO/HRD-87-55).

[d] Georgetown's estimates are formulated through staff consultation and are based primarily on litigation experience in the State of Virginia. Adjudication time may vary from state to state. These estimates are based on "typical" disposition times, whereas the GAO data are based on a calculation of "average" disposition times.

tlement rates in pretrial screening and certification procedures, which approximate the national settlement-before-trial experience.[50]

Although we limit generalization of our time-saving finding to the conclusion that the Model Act seems to accomplish its dispute resolution time savings objective, its potential in this regard is a powerful incentive for a test. This incentive is intensified by the several recent civil justice system studies.

As documented by a 1990 Report of the Federal Court Study Committee, the nation's courts face a caseload crisis of unprecedented proportions.[51] Future intensification of that crisis, absent policy change, is inevitable. From other statistical measurements of caseload growth, and exacerbated by drug and criminal trials, severe docket overcrowding is real, not mere impression.[52] Only partly related to caseload stresses, experts predict continuation of a major squeeze between public expectations of the courts and their dwindling resource bases.[53] According to many judges' observations, including those at the recent mega-conference on the Future and the Courts, civil cases are being forced off the calendar under a crisis of burgeoning caseload. Case delays may become longer as a result.[54] Considering this mounting consensus, administrative adjudication is an alternative worth serious exploration as a means to mitigate the civil justice congestion trend.

Administrative Agency Public Cost. In selecting a means to estimate costs of an administrative adjudicatory and regulatory agency, the Georgetown study adopted a very simple proxy variable in comparing the administrative alternative to courtroom litigation: cost of the forum to government. Public costs and private costs traditionally have been estimated in different accounts. We had the ability to estimate only the former.[55,56] That proposal review exercise, however, disclosed that the forum costs to the public could be significantly less than the cost of court operations (Table 14).

Public cost differentials for the administrative proposal appear to be from approximately 25% to nearly 50% less than judicial system costs for tort and civil actions. An uncertainty element is injected by the woeful state of medical tort action statistics, and it is troublingly unsatisfactory to be deprived of them.

What was startling, however, is that these costs *include* claimants' universal, free, legal representation for their private prosecution of compensatory actions against health care providers.[57] Georgetown's staff used the model statute, assumed a mid-range claims volume of 750 new cases per year, with a complaint volume of 250 complaints against physicians per year, and hypothesized a "cadillac" agency, overstaffed and highly paid, and a low cost alternative.[58] The "cadillac" was estimated at about $7 million annual cost, while the low cost alternative was estimated at about $2 million annually. These costs included operations of *both* the claims and the practice regulation subsystems of the proposed new Medical Practice Board in both high and low cost versions.

We expected that limiting estimates to the public's

Table 14

Comparison of costs to government for resolution of medical malpractice disputes under the administrative, fault-based system proposed in organized medicine's Model Act[a] and the Rand Corporation's estimates of resolution of civil tort actions brought in the state and federal court systems[b]

Forum for Resolution of Health Care Provider Tort Actions[c]	Low per Case Filed (Estimates in 1989 Dollars)	High per Case Filed (Estimates in 1989 Dollars)
State courts		
All torts	$4,739	$12,138
Civil actions	$3,792	$14,665
Federal courts		
All torts	n/a	$12,446
Civil actions	n/a	$14,129
Proposed adjudication agency for health care provider negligence[d]	$2,581	$9,436

[a] Source: Georgetown University Medical and Law Centers, Program on Science, Law and Compensation, 1990

[b] Adapted from Kakalik, J. S., & Ross, R. L. (1983, September). *Costs of the civil justice system: court expenditures for various types of civil cases*, Table S.8, p. xvii. Santa Monica CA: The Rand Corporation Institute for Civil Justice, R-2985-ICJ. Costs were adjusted to 1989 dollars using the GNP price deflator for state and local purchases of goods and services where 1989 dollars equal 1.35 1982 dollars. Deflator furnished courtesy of the Bureau of Economic Analysis, U.S. Department of Commerce.

[c] Rand "low cost" and "high cost" figures represent government expenditures for one case in low state court and high state court, respectively. The federal court figures represent expenditures for a case in U.S. District Court.

[d] While the Rand figures represent a case that goes through pretrial activity plus one jury trial, the Georgetown estimates represent a "typical" case. A "typical" case cost estimate is derived by dividing an assumed 750 claims into the high and low budget estimates.

costs would bring protest howls from people expecting another study—one financed in the millions of dollars—using real-time simulations of actual cases and encompassing all the transaction costs. Such a mythical mega-study could account for insurance company costs and would crank in the large, but currently unestimable, savings attributable to the administrative alternatives universal, free claimant-counsel plan. And it undoubtedly could account for opportunity cost savings of smaller claimants being able to enter the compensation system as well as expenditures predicted from increasing the pool of smaller claimants. However, those are modeling and simulation studies that beg for future conduct.

From our current review of purely public costs, however, the conclusion is that organized medicine's proposal possibly could be one of the dispute resolution's greatest public bargains. Any number of factors could inflate costs, and any number of bureaucratic phenomena could compromise the expenditure benefits. Such factors can be factored into a follow-on implementation analysis, one of Georgetown's recommendations. The model statute's design, *qua design*, could provide assistance to claimants and the health care professions at lower public expenditures and shorter times between meritorious claims filing and compensation awards.

Relationship between Adjudication Time and Agency Cost. At the same time, a time-related cost factor urges a caveat. Time may work paradoxically in cases that otherwise settle before final resolution in an expert agency. The overwhelming weight of opinion holds that 90 to 95% of cases settle before a final verdict. Georgetown used that assumption in estimating costs necessary to operate organized medicine's proposed expert agency. One would expect that settlement patterns would not change significantly in administrative adjudication. From most reports of pretrial screening panels, medical negligence arbitration, and, especially, Maryland's executive branch Health Care Claims Arbitration Office, cases settled in patterns similar to those observed in the court system.

It is possible that defendant health care providers and their insurers could perceive indirect incentives to drag out the adjudicatory process to the bitter end in small claims and large. Such paradoxical incentives could include last ditch resistance galvanized by automatic disciplinary review of all claims histories, and by quasi no-fault provisions that adjust insurance premiums to experience ratings in the absence of practice guidelines.

If such factors were operative, cases would still be adjudicated in shorter periods than courts could accomplish, but many more cases could span the entire adjudication timeline. This would require bigger agency staffs and more money for caseload management generally. Because the nation's data on medical liability settlements are so incomplete and unreliable, only experience will shed much real light on this puzzle. Georgetown's study report suggested some options for minimizing such paradoxical incentives, and such time and cost reinforcement mechanisms might

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be considered in pilot tests of the administrative alternative.

Implications of Medical Tort Reform in Three States

Information gleaned from Michigan, Maryland, and Virginia has been noted throughout this report. This study's staff conducted interviews, developed chronologies, and documented medical tort reform activities in the states of Michigan, Maryland, and Virginia. Each of these case studies has been published separately in *Courts, Health Science & the Law*.[59]

In addition, Georgetown's Journal published a case note about Maryland's professional regulatory and disciplinary system, itself the partial results of an empirical study conducted by a third year law student (now clerk to a Maryland Appeals Court) at Georgetown University.[60]

When added to Professor Morlock's adaptation of the Maryland experience to analysis of organized medicine's proposal,[61] and when added to the U.S. General Accounting Office's studies of Michigan, we are able to distill a few important points. These points may have implications for refinement and implementation of a fault-based, administrative alternative.

In Maryland. Maryland's experience is instructive from a fiscal perspective. The Health Care Arbitration Office, an agency of the Maryland executive branch, budgets approximately $1 million a year to hear about the same number of claims assumed in cost estimates of organized medicine's proposal. When joined to the $2.2 million budget of the State Board of Physician Quality Assurance, the professional regulatory authority, the $3.2 million total supports both functions. This lends confidence to our predictions that both claims adjudication and professional regulation functions are fiscally feasible within the $1.7 million to $7 million estimated for the Medical Practices Review Board.

In Virginia. Virginia's experience, while instructive from several perspectives, discloses the intensely political nature of fundamental decisions about tort reform. Analyst Steven Klaidman concluded that the local medical association's definition of the medical tort problem would have to match closely that fueling organized medicine's proposal. There should, in our view, be a high degree of consensus about the need to change the current system in any demonstration state.

In Michigan. While also notable for arguably the longest, most intensive experience among the states in enacting medical tort reform, Michigan points to the importance of a mandatory adjudication system. When Michigan's arbitration statute was under constitutional attack, few people wanted to use it lest it be later overturned.[62] After the scheme attained an approving constitutional review, the voluntary nature of the arbitration system appeared to hamper it severely.[63]

These observations may be used effectively in planning a demonstration of organized medicine's administrative alternative. They are merely selected highlights. Additional information may be found in the published case study reports.

Questions Unaddressed by the Study: Limitations and a Research and Evaluation Menu

Georgetown's prospective assessment obviously identified questions that lay beyond the academic staff's exploration. Most policy studies will raise questions as well as answer them. This review of organized medicine's proposed medical practices reform institution is no exception. Presented below is a discussion of several of the most prominent questions triggered, but unaddressed, by this study. They are presented roughly in order of the research staff's view of their importance. Combined in their entirety or in clusters, the suggested studies, geared to the following issues, could create a complete implementation analysis to guide a pilot test of the Medical Practices Review Board.

Limitations of the Current Study

First, in the course of this study, Georgetown conducted no projections of increased claims frequency, small claims in particular, upon the cost of a Medical Practices Review Board. During the course of our work, the Harvard review of New York's hospital population established impressive empirical bases for estimating the volume of claimants unserved by the current system. We inquired about the adaptability of the Harvard data tapes for projecting alternative pathways of claims among those 7 out of 8 medically injured people who do not file claims in the current system. We found the tapes to be usable for such purposes. Informal discussions with the Harvard study staff indicated a willingness to share the data with Georgetown staff. Use of secondary data in Harvard's several-million-dollar study would have added considerable analytic leverage to Georgetown's six mini-studies, conducted for about $100,000.

Accordingly, in Spring 1990, we formally proposed to the U.S. Department of Health and Human Services a small ($25,000) project to undertake these cost-incrementing and cost-shifting studies. After some initial encouragement, the project could not be expedited. A regular application in the Public Health Service project was recommended to Georgetown staff, but the 6 to 9 months required to approve an application proved infeasible in that the staff capable of undertaking this analysis were scheduled to move on.

Impressed that any demonstration of an administrative alternative would be fortified by congruent assessments of the current justice system's defects in medical tort cases, we sought to survey a large proportion of state legislators preparing to convene at the August 1990 annual meeting of the National Conference of State Legislatures. NCSL officials had been

contacted and had given provisional approval for an on-site survey. A sampling strategy had been formulated. Approximately 8,000 members typically attend the NCSL annual meeting, about one-third of the elected state senators and representatives. A good opportunity existed to question them about establishing an administrative alternative and the acceptability of certain of its features. The survey proposal, however, was directed into the Public Health Service's regular application process, and it was deferred.

It is still timely to conduct these studies. They would provide important new insights. Awaiting conduct, however, the information vacuum deprives our current assessment of additional avenues of information and inference, and it serves as a limiting factor in this report.

A comprehensive constitutional analysis and a policy makers' conference were also urged during the course of this prospective assessment. Lacking funding, they were not conducted. Such omissions also limit, albeit to a lesser degree, this report.

Toward a Further Study Menu

All prospective assessments raise new questions, and our limitations and other observations can serve to forge a future study menu. In the hope that the following can serve to delineate subsequent research efforts, we specify below some of the questions for which answers could yield policy maker and health care consumer dividends. They also could serve to guide test implementation of the fault-based, administrative alternative.

(1) What Would an Informed Opinion Survey among State-Level Policy Makers Disclose? After a decade and a half of medical tort reform, we are nearly as much in the dark about state legislators' views as ever. It will be important in test states—and perhaps with respect to a randomly selected national sample—to survey state legislators' knowledge, attitudes, and preferences with respect to the next stage in medical tort reform, including administrative alternatives. This task is not technically difficult and could be quickly undertaken. Our experience suggests the following dimensions of such a survey:

- What perceptions of necessity, effectiveness, desirability, and feasibility do state-level policy makers express with respect to alternative dispute resolution forums for medical dispute resolution generally, and with organized medicine's fault-based administrative system specifically?
- What perceptions exist of the comparative advantage or disadvantage of nonjudicial medical tort alternative dispute resolution among state legislators?
- How high in the public policy agenda for the several states is further enactment or regulation of medical and other health care provider practice issues?
- What outcomes or impacts are perceived in each state to have resulted, positively and negatively, from the medical tort reforms enacted in that state from the mid-1970s to the present?

Recognizing that surveys can be cumbersome and expensive, Georgetown also recommends a useful substitute: a policy makers' conference at which would be debated the great and small issues related to medical practice reform as viewed from a fault-based administrative alternative. Study staff recommend that such a conference be convened by a neutral third party—foundation, government, or academic institution. Its proceedings should be published and disseminated to the states for review by legislative colleagues across the country.

(2) What Cost Centers Would Be Impacted by a Galvanized Compensation Consciousness among Actually Injured Claimants? Delphi respondents believed that increased case filings would occur in response to establishment of a Medical Practices Review Board. At the same time—under current malpractice and complaint caseload trends—Georgetown staff concluded that the Medical Practices Review Board was affordable. It would cost very little additional money from federal, state, or private auspices, if any beyond that already spent for medical regulatory efforts. Essentially, start-up funds and those related to evaluation of an experiment would be the most prominent additional dollars required.

We also ascertained that additional forum expenses could be raised from medical personnel and user fees to a level possibly exceeding budgetary requirements. In Wisconsin, for example, the Workers' Compensation Division is budgeted by the state but "appropriated" from insurance carriers. Moreover, licensing fees could be directed to support a new medical practices institution: in many states they are a revenue source for the general treasury. In Wisconsin, the Securities Commission's operations cost about $3 million each year, but the agency raises $7 million per year. Excess revenues over budget are deposited in the state's general treasury. There is every good reason for a medical practices experimentation state to adopt such an approach. It would fund medical professional quality assurance first, and general state expenditures second.

All revenue and expenditures forecasts, however, depend significantly upon caseload. Certainly, the Harvard study documented the *potential* pool of such claims. Beyond that pool, however, the Harvard study's implications remain to be detailed and evaluated. Under various assumptions of outreach, facilitation, and minimum gatekeeping, many of the Harvard study's injured patients *may* become Board clients. How many and under which administrative protocols remain to be determined using the statistics of probability.

(3) What Would a Constitutionalizing Model Study Yield? Constitutional analysis mixing the decisions

favoring workers' compensation and other administrative law schemes with decisions decreeing other schemes unconstitutional would provide a capability for modeling the Medical Practices Review Board. Such an analysis could provide predictive forecasts. It could help contour the Model Act, if it needs such amendment, to survive as a constitutionally valid scheme.

We noted earlier that some experts are critical of the Model Act. Any proposal that, as an exclusive remedy, shifts causes of action from Article I to Article III courts requires an adequate rationale and quid pro quo. Any measure that invalidates judicial subject matter jurisdiction and abolishes a medical negligence cause of action will generate initial opposition.

Organized medicine bears the burden of a thorough analysis focused around these questions:

- In a state-by-state analysis of workers' compensation statutory interpretation, which features were found constitutionally valid and which invalid? Under which theories of constitutional application?
- Which of the principles could or might apply to the administrative systems for medical practices reform? What implications could such applications have for generating amendments that would assure that the Model Act could pass constitutional muster?
- What role, if any, might the fault concept play to differentiate organized medicine's proposal from constitutional analyses of workers' compensation statutes that emphasize the no-fault concept?
- What features of medical tort reform were found constitutional under which features of the appellate law?
- What alternative scenarios, and probability assessments attached thereto, could be envisioned to maximize Model Act constitutionality and minimize vulnerability to constitutional attack?

(4) What Would a Special Analysis of Standard of Care Yield? Changes in the standard of care by means of which doctors are held to be at fault may be a profound element linking the adjudication, regulation, and tort reform systems comprising organized medicine's approach to a new medical practices institution. The Model Act would establish a reasonableness standard to replace a community standard. It would exculpate any act or omission that fell into one of several exonerating categories of professional performance.

Standard of care has been a major issue in legal medicine for a long time. Georgetown's review touched only superficially upon it. Delphi respondents viewed the combination of tort reform and standard of care rules as one possible source of unfairness in organized medicine's Model Act. Their net impact, they argued, would be to lower health care quality standards in the attempt to lower liability thresholds.

Without concentrated attention to this issue, we can only raise questions that in further operational research or conferences warrant answers:

- What would the practical impact be upon various classes of medical negligence litigants were standard of care rules to mirror the "reasonableness in the same or similar circumstances" standard urged in the Model Act? How would impacts differ from those experienced with respect to the community standard rule, now the majority rule, and the national standard rule, urged by some?
- Were the model statute to be amended by addition of practice guideline development mandates, how would such addition be affected, if at all, by the currently adopted standard of care?
- If, as some experts pointed out to Georgetown's academic staff, the Model Act's standard of care were adopted in a large, diversified state, would such standards reinforce tendencies to allocate lower quality health care to the lowest income citizens of that state?

(5) What Effect Would Inclusion of Episode-Related Defendants Have upon the Administrative Forum's Procedures? One concern expressed by the Advisory Committee to Georgetown's project is a procedural problem, the result of carving out for administrative adjudication acts and omissions that may have multiple defendants, such as pharmacists, pharmaceutical companies, or medical device manufacturers. These latter groups are not included under the Model Act's definition of "health care provider." A similar professional regulation problem concerns doctor oversight and discipline, which omits nurses, physical therapists, and other health care providers.

To deal with these excluded groups, we recommend that a workshop be established to analyze the practical effect of excluding certain groups and professions from the coverage in the administrative, fault-based alternative. Questions could include:

- Using simulations, to what extent, if any, would procedural entanglements result from inclusions and exclusions mandated by the Model Act's current version?
- What remedies or amendments might be proposed to relieve procedural snarls, if any were found?
- What cost, time, administrative burdens, or benefits factors could accompany changes in the personal jurisdiction of the proposed Medical Practices Review Board, in both claims and regulatory functions?

(6) How Could Incentives Join Disincentives in the New Medical Practices Institution so as to Reward, Not Merely Deter or Punish? Many experts and

Georgetown staff observed that the fault concept provided the linking undercarriage among the Model Act's adjudicatory, regulatory, and tort reforms. It retained the concept that a health care provider is responsible for a patient's care, a historically durable meta-notion upon which ethical codes are based and can be interpreted.

At the same time, we noted that incentives could be built into negligence prevention, not merely the awful wrath of the law paraded as a threat of punishment for deviation. By reducing professional liability insurance premium costs, for example, for low liability claims incidence and prevalence, health care providers can enjoy a benefit from exemplary performance. By awarding exemplary performance citations, including financial and nonfinancial recognition, excellence strivings can be reinforced as a matter of public policy.

Perhaps such matters can be handled by the rule-making powers delegated to the proposed Medical Practices Review Board. But consideration might be given in a systematic way to their inclusion in a model statute.

(7) What Would Qualified No-Fault and Graduated Compensation Schemes Do to the Model Act's Quality Assurance Objectives? We ask these questions without further specification. They will require the collaborative effort of many disciplines.

(8) What Would an Integrated Medical Practice Guidelines Effort Do to Spur Medical Quality Assurance? Lurking in every recent proposal to quit the expensive practice of defensive medicine and structure provider and consumer health care expectations is reference to practice guidelines. An accountability and measurement device as well as a set of operational objectives, a medical practice guidelines program holds promise of spurring medical quality assurance. It also provides a template, along with the other questions and suggestions discussed above, for evaluating a test of the administrative, fault-based agency.

We suggest that the mandate to undertake such development should be a high priority of the proposed Medical Practices Review Board and should be inscribed in a pilot state's enabling statute.

(9) What Would a Knowledge Production Objective Require? Throughout Georgetown's association with this proposed medical practices institution, organized medicine has reaffirmed its commitment to an experimental trial of an administrative alternative. In the course of our prospective assessment, however, a more compelling, implied objective surfaced. Clearly, the Model Act would create a public policy and health care delivery laboratory. The states, it has been agreed, are the laboratories of our democracy. Organized medicine equips those laboratories with a new dimension for knowledge production. It could create an innovation with its own learning vehicle attached. It provides a base for evaluative research. Adopted in several locations, it could provide the best foundation for health policy studies in the nation's history.

Accordingly, we suggest that this purpose be added to the Model Act's findings and purposes. This addition could serve as the necessary license to augment a bold and comprehensive scheme with an equally comprehensive research and policy development strategy.

Conclusion: Considerations for Amending Organized Medicine's Proposal

The purpose of the commissioned papers, special purpose surveys, and the experts survey was not to reach consensus on the merits of organized medicine's proposal. Indeed, by selecting experts from different fields, and by mobilizing a mosaic of limited scale studies financed with limited funds, we practically ensured a divergence of opinion. Rather, we sought insights into the nature of the debate and the issues. The intended purpose of our on-site studies was to highlight the fault-based administrative proposal's feasibility and to suggest obstacles its implementation might face.

From these diverse information sources, we conclude with respect to the key issue: the proposal warrants implementation. There is widespread, but not universal, support for a pilot program. We further conclude that an expert agency approximating that set forth in organized medicine's Model Act is capable of implementation in a hospitable state that seeks to improve the quality and quantity of medical dispute resolution. As for political matters, it seems clear that such hospitality would be enhanced in states that share the proposal's underlying, coordinated reform objectives, discussed earlier in this report.

Our study indicated that there was general agreement that at least certain aspects of the current system are deficient. Even plaintiffs' and defense counsel, arguably the groups most benefited from civil justice system operations, seemed to acknowledge the problems. Understandably, they are chary of risking the virtues of a known system for the uncertainties of alternatives. The common-sense political economy of medical practices reform dictates that they must be given an opportunity to participate in and benefit from an administrative alternative.

There is disagreement—or at least a lack of evidence as to important factors that handicap the current system: why 15 out of 16 actually injured health care consumers fail to be compensated, or the actual incompetence of juries to fairly compensate such persons, for example."[4] The experts concurred, however, that for many reasons, many injured patients are not able to access the current system. This causes a dysfunction within the tort system with respect to its dual goals of compensation and deterrence. There were shades of difference on these points, but sufficient commonality pointed to the need to find certainty in a fair and efficient alternative. Policy makers who share these observations and seek health care consumer access to a medical injury compensation

system should find organized medicine's proposal attractive. Recent citizen surveys about the civil justice system seem to indicate that the public is ready for improvement.[63]

There was general agreement that the administrative alternative represents an important contribution to the debate; it is not one-sided; and in many respects, the proposal presents a balanced approach. It will, its specific features aside, be an important challenge to the legal and public administration professions in approaching issues of medical liability.

It is clear from a review of our six mini-studies that the issue of malpractice reform cannot easily be removed from the sharp political overtones that typically have characterized the debate. Despite organized medicine's best efforts to elevate the issue of reform above any underlying political agenda, that goal probably has not been reached. In this regard, the proposal's sponsors may be required to go significantly more than half-way to convince policy makers and health care consumers that the proposal is in their interests and that it serves their mutual purposes.

Our state studies, particularly the Michigan medical tort reform experience, imply policy makers' and health care consumers' needs for guarantees that the proposed Medical Practices Review Board would possess the necessary resources and commitment to enforce the adopted negligence standard effectively. Another concern will be whether the Board would be, in fact, impartial. Despite Morlock's suggestion that use of medical professionals in a decision making capacity was not a problem in Maryland's experience, the fact and the appearance of impartiality remains a first order objective as organized medicine moves from the design to the implementation of its model.

The structure of organized medicine's proposal is designed to be impartial. It is not inherently biased. The appointed Medical Practices Review Board would have a majority of nonmedical, citizen members. As the expert agency's fairness centerpiece, claimants are provided free legal representation. The proposal's sponsors, however, appear to be specially challenged: they must overcome the political and social suspicion, if not presumption, that innovations proposed by organized medicine cannot be in the public interest, partly because medical expertise must be brought to bear in every compensation claim and in every disciplinary charge.

This observation poses an unanswerable dilemma.[64] If a primary problem of the current system is its lack of expertise, then medical involvement is necessary; if medical expertise is inherently biased, then medical involvement cannot be included without sacrificing the necessary neutrality. Our Delphi experts, however, were persuaded that medical scientific evidence would be effectively utilized in the proposed administrative forum. Assuming that the investigators and administrative law judges chosen as the new expert agency's operatives will be a mixture of medical and legal personnel, an empirical analysis of medical professionals as legal decision makers may be necessary to determine the nature of any medical bias. Only outcome research and external monitoring for sufficiently long operational periods will be able to illuminate this matter.

The appearance as well as the fact of impartiality, however, can be structured into minor amendments in the Model Act. We recommend that such amendments be given serious consideration.

Going the Extra Mile: Some Suggestions for Elaboration and Amendment of Organized Medicine's Proposal

Fairness: The Claimant Advocacy Centerpiece. Somewhat to our surprise, we found that experts upon whom we relied early in the study for analyses paid scant attention to the proposal's legal representation feature. Our contract paper authors commented only indirectly and superficially about this feature, albeit favorably. A majority of our Delphi survey respondents opined that case filings would be increased, costs to parties lowered, and stress to parties alleviated by the proposed agency's operation, in part due to furnished counsel. But only two survey respondents of the 29-expert queue made direct comments about legal representation; both comments were favorable. Georgetown research personnel noted that a fault-based administrative bill readied for Utah and one introduced in Vermont relied upon outside counsel panels, but reserved this feature's elaboration to rule making under the proposed new agency's authority. This relative silence about claimants' guaranteed legal representation left Georgetown research staff in a quandary.

We had estimated, using our step-flow and elapsed time analyses, that in a "typical" state receiving 750 new claims per year the cost of *outside* legal representation would equal and could far exceed the costs of operating the Medical Practices Review Board. On the other hand, using state-employed attorneys with even modest caseloads, the proposed agency could comfortably pay for counsel within a typical operating budget.

Costs aside, we inquired about legal representation in four case study site visits and at a workshop on workers' compensation agency analogues to the proposed new medical practices agency. From such interviews and discussions, we derived three additional criteria for effective legal services. Their satisfaction appears to be crucial to attaining enhanced access and to achieve the appearance and the fact of impartiality.

First, agency-provided claimants' counsel must be free from conflicts of interest in appearance and in reality. Second, agency-provided counsel must actively assist access to the claims adjucation system. Third, agency-provided counsel must substantially have at their disposal the same tools and incentives available to independent advocates. Study staff applied these criteria against provisions of the Model Act establishing the proposed Medical Practices Review Board.

Conflict-Free Claimant Advocacy. The new institution's Model Act provides for staff attorneys assigned to claimants. Those attorneys report to the agency's general counsel. Our analysis concluded that the intention (free, universal legal representation) could be compromised by these reporting relationships (implying that attorneys must represent the agency's interests at the same time they advocate their clients' causes). We observe that this slip between intentions and organizational design could be easily remedied; staff attorneys could be appointed according to civil service guidelines in a quasi-independent advocacy unit, fiscally responsible to the Chairman of the proposed Medical Practices Review Board, but professionally self-contained except for an independent, non-paid, professional standards advisory committee mandated to issue periodic reports to the public about the Board's advocacy progress.

Active Assistance of Counsel. The Model Act would assign free counsel (while permitting each claimant the option of his or her own, private counsel) after the proposed Board's claims investigator has issued the equivalent of a certificate of merit for a given claim. Georgetown's research staff concludes that active assistance of counsel, and effective access to the dispute resolution forum, hinge upon effective framing of an initial claim. Legal assistance at the time a claim arises—before any investigation or adjudication—is in our judgment required to attain active assistance of counsel.

Going the extra mile to attain active assistance of counsel must involve the trial bar, particularly the plaintiffs' attorneys. Plaintiffs' counsel is experienced in case-finding and prosecution. They possess the experience and track record necessary to galvanize the active outreach built into the administrative alternative's mission. Moreover, the plaintiff's bar is an active political force in most states whose approval for a demonstration effort would constitute an important endorsement.

For these reasons, organized medicine should consider amending its Model Act to include the plaintiffs' bar, specifically, and the legal profession, generally, in setting the standards for and the delivery of legal services. Many operational options are available.

One option is to allocate legal services randomly to claimants, assigning Board-employed attorneys to one claimant cluster and private practitioners to another. In this way, outcomes can be compared, and the best means of standardizing the Medical Practices Review Board's legal services can be measured. Per case payments in the nature of retainers can be made to private counsel with the remainder to be collected through the contingent fee policy already built into the administrative alternative's tort law. That policy caps contingent fees at 20% of claimant payments. This is the allowable maximum typically provided in workers' compensation agencies. It appears, therefore, to be a realistic starting point for negotiations with the plaintiffs' bar in a state evidencing interest in the administrative alternative's pilot test.

Advocacy Tools and Incentives. While the Model Act is silent about attorney-client privilege, avoidance of the appearance of conflicts of interest would be served by an express statutory provision authorizing operationalization of that ethical canon. The Model Act sets the standard of legal care as much as it sets the medical standard. Equally as important, claimants' advocates should expressly be provided all necessary discovery tools. Less usual, but worth considering in organized medicine's ground-breaking, future-regarding proposal, Georgetown believes that financial bonuses for the Board's claimant advocates could be established on a merit-achievement basis. Whether such an incentive system be predicated upon compensation percentages, client satisfaction with advocacy services, or general work product quality remains to be addressed in subsequent implementation analyses.

Fairness in our civil justice conception significantly is related to established principles of due process in the adjudication of important disputes. Several critics have raised concerns that organized medicine's proposal is defective for reasons related to the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution. We describe below several nagging and irrepressible constitutional issues shadowing the proposal. Georgetown's prospective assessment, however, concludes that effective legal representation providing real access to an authoritative dispute resolution forum and earliest possible compensation to injured parties could be an excellent—arguably, the best—guarantor of due process.[57] The Model Act is not far from such guarantees, and from freedom of interest conflicts, in fact and in appearance.

Balanced Forum Governance, Active Outreach, and Minimum Gatekeeping. While latent fairness in organized medicine's proposal is thus heavily related to legal representation, our study pointed out that fairness is also related to the composition of the forum itself—whether it is objective or stacked against one or another of the contesting interests.

In all states, medical regulation currently is dominated by the medical profession.[58] In many states, administration of medical professional oversight and discipline is entrusted exclusively to the medical profession. These entities in recent years have been bombarded by criticism, in part due to their medical governance.[59]

In organized medicine's proposed scheme, the seven-member, governor-appointed, Medical Practices Review Board would be comprised of four or more nonmedical persons and not more than three medically trained members. In terms of sheer numerical balances, then, the Model Act reverses governance proportions and places the lay public as a dominant force. This overall governance design element is carried into day-to-day adjudication and regulation. Three-member panels reviewing administrative law judge recommendations for compensation and disci-

pline would be comprised of two lay members and one medical member. Cynical thinkers could condemn the scheme as a sham and assume that the nonmedical members would front for medical interests. To assuage such concerns, organized medicine could statutorily mandate the Board to publish structured, periodic reports, rather than leave the matter to agency rule making. Going the extra mile in this respect leads to the adoption of continuous decision analysis. Such analysis can be conducted unobtrusively and periodically, as part of the evaluation package appended to the expert agency's pilot operation.

Such reports would be one of several instruments of public outreach upon which the new institution's success depends. Other outreach methods could include prominently advertised 24-hour 1-800 telephone numbers; on-line computer-assisted access from libraries or video-tax services, courthouses, fire departments, and other civic utilities; broadcast media prominence, including interactive radio and cable-TV channels or programs; newspaper columns and public interest advertisements; attractively styled and clearly worded informational brochures distributed to every health care provider. Such measures to implement active outreach customarily are delegated to agency rule making. But to assure their prominence, organized medicine's statutory scheme easily could be modified to specify and mandate them.

Bureaucratic barriers were the voiced concern of several experts assisting the Georgetown University prospective assessment. A periodic access impact review requirement imposed upon the Board would lift the issue to high priority. Just as important is circulation of claims forms and directions permitting claimant (in injury cases) and complainant (in disciplinary cases) completion with minimum help. Coupled with the availability of Board-provided counsel, we see no reason why gatekeeping barriers would frustrate organized medicine's statutory scheme.

Organizational complexity bothered a few of the study's commentators and advisors. Why, they wanted to know, was the Model Act so complicated? After 18 months of living in close proximity to the 300 pages of description and statutory language setting up three subsystems—claims adjudication, professional regulation, and medical tort reform—study staff began to appreciate how hard it has been to get one's arms around the proposed new medical practices institution. It took 2 years to craft the proposal, and it is unrealistic to expect even experts to appreciate its scope and nuances in a short time. We diagrammed the procedural dynamics of the claims and disciplinary functions and compared them with the procedural labyrinths embedded in judicial system resolution of medical tort actions.[70] In practice, we concluded, the administrative system would be no more complex, and possibly less redundant, than litigation.

With additional and simple safeguards discussed earlier, Georgetown's academic staff concluded that fairness latent in the proposed administrative agency could be made manifest. No-fault medical tort schemes could be less supportive of medical practice reforms without substantially reducing the bureaucratic component already blocking professional oversight and needed to administer medical injury claims. And the service ideal, while always subject to worst practices by bad government, can be reified by best practices in good government.

On Constitutionality. Several authors and experts noted the likelihood that the administrative alternative would very likely face significant constitutional challenges. While the constitutional issues are beyond the scope of Georgetown's study, our mini-studies and our legal development monitoring may contribute to an analysis of the proposal's constitutionality. It is an issue that lay outside of Georgetown's study protocol, mainly because we did not have the funds with which to study it properly. At the same time, we constantly encountered the proposal's presumed constitutional validity or invalidity.

The administrative, fault-based proposal abolishes medical tort as a cause of action and prohibits state court subject matter jurisdiction over civil actions for medically induced injury brought by any patient-plaintiff against any doctor-defendant. Some observers opined that such provision, per se, offends the right to jury trial guaranteed by the Seventh Amendment. Others thought that trading a theoretical access to a jury trial for an actual access to prompt expert agency adjudication with free counsel was sufficient quid pro quo for establishing a nonjudicial exclusive remedy and would pass constitutional muster.

Nearly a century ago, the magic words of the law were crafted into constitutionally approving form to bring peace to another segment of the population—employers and employees. The economy was endangered by threatened strikes, related, in part, to workplace injuries. Injured workers' access to the civil justice system was difficult at best. As partial access resulted in increasing prices of the right to action through escalating jury verdicts, however, a means of equalizing the compensatory burden and of reinforcing regulation of employer practices was sought by multiple interests.[71] The analogy has value for a fractious 1990s medical practices constituency lurching toward a better equilibrium of rights and interests.

From 1900 to 1940, the workforce's morale—the engine of our industrialized society—was severely bruised and in need of public policy first aid. The workers' compensation system was designed, and early adopting states, in effect, began public policy experiments that established new institutions after a period of constitutional testing.[72] Many authorities now support such innovation in service to health care quality.[73]

If the law placed great value on employer-employee harmony in this century's first decade, several Georgetown experts reasoned, legislators could choose policies to similarly promote more harmonious rela-

tionships between health care consumers and health care providers during this century's last decade. The pilot testing of an alternative is a better means to such objectives in terms of quid pro quo considerations and public confidence, according to some writers.[4] Deliberate re-invigoration of such relationships could promote health quality and possibly slow the past two decades' steep rise in medical care costs. No prohibition upon such policy decisions—constitutional or otherwise—exists a priori, according to this school of thought; all barriers are political, fueled by economic self-interests of the service industries interfaced with medical practices. If the political will and energy are available, this view holds, legislation shifting medical negligence from Article III to Article I courts could be grounded in a rational nexus and immunized from constitutional attack by providing the same quid pro quo that workers' compensation legislation offered to employers and employees: guaranteed adjudication access and timely compensation for injury in fact.

Not surprisingly, these majestic, Seventh Amendment-related, constitutional questions are intermingled with arguably more pedestrian, but important ones. The model statute's judicial review provisions, for example, drew due process criticism, especially from experts who are members of the trial bar. Two problems recurred in commentary. The first was the elimination of trial de novo upon exhaustion of administrative remedies or, in the alternative, substantive appellate tribunal review. The second was using health care providers as administrative law officers in the administrative system.

We believe these issues deserve analysis with a view toward contouring the Model Act's features to win constitutional approval. However, it is important to make several points.

First, workers' compensation systems do not, for the most part, permit trial de novo. What, besides the no-fault provision, differentiates the constitutional pluses and minuses to urge trial de novo in medical injury adjudication? If the fault/no-fault dichotomy is crucial, a detailed analysis implicating it would be essential. Second, the substantive appellate review documented in the Wisconsin Division of Workers' Compensation discloses an overwhelming approval of substantive adjudication at lower levels. With only 485 appeals of over 77,000 claims filed in 1989, for example, 76% of such appeals were affirmed at the first level of administrative review, and 81% of appeals in the court of appeals sustained administrative decisions. These figures suggest that substantive review in a real expert agency may be truly efficient. If qualification for constitutional approval hangs on maximum efficiency as one indicium of fairness, such conditions may well occur with respect to organized medicine's medical practices model as well as Wisconsin's adopted employer practices policy. Finally, guaranteed legal representation, discussed above at great length, would appear to offset any occupational bias imported into administrative law positions. Subsequent analysis could test this hypothesis with specificity.

Moving across the Fourteenth Amendment's landscape, several critics raised the possibility of the Model Act's vulnerability to equal protection challenges. They informally questioned the constitutionality of a medical carve-out from more general attempts to reform the tort system. That question was also raised in this project's advisory committee deliberation of contracted papers. Why, it was argued by one commentator, should physicians be given their own negligence-mitigating institution? That is certainly a question loaded with assumptions susceptible to analysis and testing. It may, however, mask a more fundamental one leveraging more important analysis: if medical practices and quality improvements were the Model Act's integrated policy objective, why wouldn't an authoritative, public-dominated new institution capable of reaching such objectives be created in the public interest?

In this vein, another Delphi respondent, a Model Act proponent, asked why the public shouldn't be given a coordinated means of bringing medical practices under control? Others answered with a question not invalidated just because of its circular reasoning: why shouldn't health consumers and health providers be entitled to their own institution if the public's interest in health care quality is a dominant policy objective?

While in no way dispositive, the issues cry out to be systematically examined. Taken together, these questions urge concentrated attention, even if they cannot all be answered sufficiently or satisfactorily at the present time. It *is possible* to study the several constitutional questions described above. To date, however, such studies have not been undertaken.

Georgetown's Program for Science and Law published one constitutional analysis by members of the Defense Research Institute (Reynolds, H. E. Jr., Lockwood, R. G., Smart, C. H. Jr., & Schiferl, K. C. (1990). A constitutional analysis of the American Medical Association's Medical Liability Project Proposal. *Courts Health Science & the Law, 1*, 58-74). That analysis concluded that organized medicine's proposals suffer constitutional flaws, any one of them possibly fatal. It is a well-reasoned position, but it is rooted in the current system and fails to recognize any flaws therein. It also was based on an assumption that the Model Act would be adopted as a permanent and fixed policy by some state. In this respect, the analysis did not credit the Model Act as a public policy experiment. Perhaps this misinterpretation was fostered by organized medicine's failure to include in the Model Act a sunset provision. Perhaps it was triggered by the omission of a knowledge production finding objective and provision, the charter element of a public policy experiment. Both are recommended for organized medicine's consideration. Both would represent the sponsors' willingness to go the last mile.

Beyond the new medical practice institution's pro-

posed pilot status, the Reynolds article features two important shortcomings: (1) it failed to look at innovative, related public policies—such as the workers' compensation system—that survived constitutional challenge;[76] (2) it was a position argued by a party at interest in the current justice system whose self-interest must be assumed over the public's interest by its one-sided, straight-line, contextless, approach.[77]

The fact is simply that *no* independent, thorough, and comprehensive constitutional analysis has been applied to the Model Act. The question still daunting organized medicine's proposal is, "Can such an even-handed analysis be designed and implemented?"

Georgetown's study staff answers in the affirmative. It would be possible to mobilize a workshop in a neutral setting for this purpose. The workshop would require prepared papers. Those required papers could be written to highlight the various features of organized medicine's proposal.

Organized medicine's insurance companies—the physician-owned companies writing 50 to 70% of physicians' medical liability policies—proposed the constitutional matter be quieted by giving health consumers a choice of dispute resolution forum in a rival, similar proposal for a new administrative institution limited to medical tort claims adjudication. This almost certainly would moot the constitutional issue. But it also might condemn usage of the new institution. Georgetown's case studies, the workers' compensation system, and less-than-conclusory alternative dispute resolution studies suggest that an authoritative forum tends to be ignored unless the power of the law rests foursquare behind it and mandates such usage. A case in point: a recent report issued by the U.S. General Accounting Office discloses Michigan's voluntary medical dispute arbitration program virtually to be ignored. "We do not see any immediate potential for increased (medical arbitration) program participation," GAO wrote senior members of the Committee on Ways and Means, U.S. House of Representatives, on December 27, 1990, "because of the voluntary nature of the program and lack of incentives for patients to participate."[78]

Beyond questions of the mandatory or voluntary nature of an alternative to the current system, we were impressed with the flexible attitude shown in our surveys toward the administrative proposal's fundamental principles—to take medical malpractice out of the courts and vest dispute resolution in a workers' compensation-type agency. About one-third of survey respondents expressed neutrality about the issue, and the remaining two-thirds evenly split for and against the proposition. It is possible that these "neutrals" would be swayed by arguments for either side not advanced in Georgetown's simple surveys. It is equally as possible that the 1990s climate for dispute resolution innovation has begun to soften positions about dispute resolution policy. One example of that increased flexibility appears in the Federal Courts' Study Committee's recent report.[79]

The FCSC, a congressionally mandated, blue-ribbon planning unit, investigated the federal courts' current caseload crisis and made a host of recommendations for change. The Committee recommended that Social Security Disability cases be removed from the courts and adjudicated administratively. It recommended that Congress create a new Article I court to do the job. In so recommending, the FCSC made the following observations:

> "...Social Security disability cases do not receive, on average, the sustained or expert attention from the Article III courts under the present system as they would under a system of expert adjudication concentrated in a single court so that responsibility is not diluted."[80]

Moreover, the Committee recommended to Congress another pilot test: administrative adjudication of equal employment opportunity discrimination claims. These subject matters are as dearly held with respect to rights, powers, privileges, and immunities as issues typically litigated under the medical liability rubric. One could reasonably assume due process sensitivity to such matters by FCSC members in respect to disability and discrimination claims. The FCSC's comments are instructive:

> "The interests of a class of vulnerable citizens are promoted, not sacrificed, when a system of adjudication can be tailored to their particular needs, as we propose be done. The *fairness of the adjudicative system, as distinct from the factual correctness of particular decisions within it*, would remain fully reviewable in the Article III courts."[81] (Emphasis supplied.)

The courts are entering a period of innovation. Perhaps the FCSC—comprised of judges, congressmen, and the nation's top lawyers and legal scholars—believes that rights can be guarded in multiple forums, and powers can justiciably be exercised by administrative law judges. Privileges can be recognized and immunities enforced by dispute resolution alternatives to the courts, the nation's top justice system panel seems to say. In many ways, the FCSC's recommendations seem to parallel initiatives suggested by organized medicine's proposal.

Our recent study of the future and the courts also evidenced considerable support for alternative dispute resolution amid a judicial system future in which "All civil matters seem destined, according to a majority of survey participants, to be displaced by the criminal calendar's speedy trial requirements."[82] At the same time, considerable support was expressed for the proposition that classes of disputes, including medical malpractice, be diverted to alternative systems "within the court structure or in administrative agencies, to deal with repetitive adjudications using well settled law for which the judicial forum may intensify adversariness through judicial delay."[83]

Medical malpractice has been the nation's tort reform laboratory. Between 1975 and 1990, every ju-

risdiction, with the sole exception of the District of Columbia, enacted tort reforms to ease strains imposed by the unavailability and high cost of medical liability insurance, loss of doctors, and a climate of conflict between health care consumers and health care providers. Substantial innovation has been incorporated in the states, the leading edge of tort reform and alternative dispute resolution generally. While no comprehensive impact or outcome studies of this experience have been conducted, most reform features, after a period of constitutional testing, have settled into patterns supportive of the law's intent—to compensate victims of medical negligence and deter malpracticing doctors. The problem is that few people are confident that the law's intent in the current system effectively is being attained. With federal and state court leadership considering alternative dispute resolution using administrative forums, it seems timely and warranted to move medical tort reform into an operational test status, as Randall Bovbjerg puts it, "toward win-win reforms."[84] Organized medicine's proposal for a fault-based, administrative system can serve as a win-win reform.

Moreover, no commentator in the course of the Georgetown prospective assessment suggested that medical professional regulation was functioning well and required no reform. During the course of the study, the U.S. Department of Health and Human Services reported coldly and flatly that medical professional discipline in the states is not working.[85] At the same time, Congress passed legislation mandating a central registry of malpractice actions, a clearinghouse to detect repetitive events in medical liability judgments.[86] Therefore, as to professional oversight and discipline, innovation appears strongly to be favored in the pursuit of quality medical care. To the extent that quality medical care is that free of medically induced injury, medical practices reform as suggested by the Medical Liability Project is overdue. It is ripe for experimentation in new, more effective approaches.

Georgetown's study report regrettably leaves constitutional issues as inadequately addressed as they were at its outset, 18 months earlier. This situation need not endure, however. Combinations of analysis and simulation can help surface the constitutional issues in the context of policy choice and change. We recommend such efforts. The sooner the better—in the public's interests.

Furthermore, it would be possible to model organized medicine's proposal to reflect a constitutionally permissible alternative archetype. That is, empirical documentation of state high court rulings about administrative agencies featuring Article I courts can flag and corroborate factors challenging to a new medical practices institution's underlying legislation. It would then be possible to computer-model "acceptable" legislation that would pass constitutional muster at various degrees of probability. These predictions can be statistically simulated. The question, "Is organized medicine's scheme constitutional?"—so one-dimensional and self-serving in neat "yes" and "no" wrappers—then yields to a different, more objective, more instrumental, multi-dimensional one, "Under what conditions, based on analogous administrative schemes, could organized medicine's scheme constitutionally be optimized, maximized, and minimized?"

Positions on these issues revealed a conflict between competing visions of the tort system.[87] Clearly, the current litigation system creates a rights-vindicating market with risks for both plaintiff and defendants. If the medically injured patient is skillful or lucky in choosing counsel, the current system is desirable. Thus, fair results occur in these cases. In other cases, however, no lawyer is willing to accept the case, resulting in a system properly categorized as inconsistent. The competing value underlying the tort system—just as traditional as the prosecution of claims by the afflicted individual—is consistency in being restored to pre-injury condition. Those praising the litigation system appear to elevate the game principle over the consistency principle. Administrative adjudication advocates, on the other hand, champion the consistency principle. It would regulate behavior and create professional accountability among health care providers. At the same time, litigation system supporters valued the higher levels of compensation that they thought severe iatrogenic injury would be awarded at settlement or trial. Administration advocates valued controlled compensation, which usually means lower payments, in exchange for efficient compensation procedures and more conservatively enunciated standards of health care.

Concluding Comment

Georgetown's researchers believe that such polemics should be brought to a close in favor of demonstrating models that have a chance to work. Organized medicine has shouldered the responsibility of advancing a feasible model. The model deserves to be tested. Such a test should evaluate systematically advantages predicted for the nation's health care consumers, particularly those injured, uncompensated patients lacking access to the legal system.

Georgetown's researchers conclude that the model, with a few changes, can be demonstrated and that such a demonstration can be evaluated to the satisfaction of the state-level policy makers in whose hands rest the next installment in our attempts to achieve quality health care. It is time to forge a creative, productive truce between medicine and justice.

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of America. This paper represents only the views of the authors and not those of any granting institution.

Georgetown University's academic staff took responsibility for study design, conduct, analysis, and this report. The study's staff was aided by an advisory committee that met three times—at the study's initiation, midway to deliberate four contracted papers; and at the study's conclusion, to review a draft report. The advisory committee, however, neither approved nor disapproved the study, sole responsibility for which lies with Georgetown University. Advisory comments were gratefully received, but this assessment's publication carries neither the committee's endorsement nor that of any of its members. While the advisory committee included a broad-based cross-section of medical liability interests, the absence of the organized plaintiffs' bar representation deprived the study staff of that sector's views. One advisory committee member had been a plaintiffs' attorney, and several plaintiffs' attorneys provided interviews and Delphi surveys.

Medical Malpractice Alternative Evaluation Advisory Committee members included the following persons, among whom only the study funders officially represented their employing organizations. For others, organizational affiliations are named only for purposes of reference: Christopher Bladen and Mary Byrnes, U.S. Department of Health and Human Services; Leslie Cheek III, Crum & Forster Insurance Companies; Deborah Chollet, Georgia State University; Martin Connor, American Tort Reform Association; Bertram Cottine, Bureau of National Affairs, Inc.; David J. Daneiski, Stanford University; the Hon. Dave Durenberger, U.S. Senator, Minnesota; Ronald Gass, American Insurance Association; Bryant Galusha, M.D., Kenneth Heland, American College of Obstetricians and Gynecologists; the Hon. Thomas P. Jackson, U.S. District Court, District of Columbia; George McGee, M.D.; Sally Narry, U.S. Small Business Administration; Robert Patterson, Pennsylvania Blue Cross; Seymour Perry, M.D., Georgetown University (Chair); Larry P. Polansky, Esq.; Jean Polatsek, American Hospital Association; the Hon. Joshua L. Robinson, 26th Judicial Circuit, Courts of Virginia; Victoria P. Rostow, Powell, Goldstein, Fraser, & Murphy; the Hon. James H. Scheuer, U.S. Representative, 8th District of New York; Dr. Howard Shapiro, American College of Physicians; Geoffrey R. W. Smith, McDermott, Will & Emory; James S. Todd, M.D., American Medical Association.

The study's academic staff included: Professor Franklin M. Zweig (principal investigator from 1/1/90); Sandra S. Thurston, Esq.; Pamela S. Coukos, S. Diane Turpin; Christopher G. Jernigan; David C. Judge, Edward J. Burger, M.D. (principal investigator to 12/31/89); Dr. Rosita Thomas (consultant); Clifford A. Dougherty, Esq. (consultant).

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Endnotes

1. Medical Liability Project, American Medical Association/Medical Specialty Societies. (1988, January). *A proposed alternative to the civil justice system for resolving medical liability disputes: a fault-based administrative system.* Chicago: American Medical Association. Medical Liability Project. (1989, May). *Tort reform codification model medical liability and patient protection act.* Chicago, American Medical Association (hereinafter referred to as the "Model Act"). See also *Courts, Health Science & the Law, 1,* 87–120.

   For a description of the proposal and its rationale, see Johnson, K. B., Phillips, C. G., Orentlicher, D., & Hatlie, M. J. (1989). A fault-based administrative alternative for resolving medical malpractice claims. *Vanderbilt Law Review, 42,* 1365; K. Johnson, K. B., Phillips, C. G., Orentlicher, D., & Hatlie, M. J. (1990). The American Medical Association/Specialty Society tort reform proposal: a fault-based administrative system. *Courts Health Science & the Law, 1,* 6–18; see also Phillips, C. G., & Esty, E. H. (1989). A fault-based administrative alternative for resolving medical malpractice claims: the AMA-Specialty Society Medical Liability Project's proposal and its relevance to the crisis in obstetrics. In Roston, V., & Bulger, R. (Eds.) *Medical professional liability and the delivery of obstetrical care, volume II, an interdisciplinary review* pp. 136–160. Washington, DC: National Academy Press (Institute of Medicine). For ease of reference, the proposal will be referred to here simply as the "organized medicine proposal."

2. The proposal was endorsed in 1989 by the Institute of Medicine (IOM), a prestigious arm of the National Academy of Sciences. In its study of the impact of medical liability upon the obstetrics and gynecology fields, IOM stated, "the (study) committee determined that, based on the theoretical literature available, three alternatives appear particularly promising (including organized medicine's proposal). . . and recommends that states evaluate these three proposals, among others, for implementation on a limited basis. . . ." No-fault and private dispute resolution contracting were the other institutions recommended.

   However, earlier reactions to organized medicine's proposal were less enthusiastic; see Stevens, C. (1988, March) Can the AMA sell its own brand of tort reform? *Medical Economics, 65,* 23–29. [Experts in the medical, legal, and insurance fields were interviewed about organized medicine's proposal and labeled the plan as everything from brilliant to outrageous. James S. Todd, M.D., then Deputy Executive Vice President of the American Medical Association, stressed the plan's intention to increase the number of patients who can have their claims evaluated, because they will no longer have to convince lawyers to take their cases; Harvey F. Wachsman, a New York neurosurgeon-turned-plaintiff's-attorney, was quoted as saying, "I hope people won't be fooled into expanding the power of state medical boards that don't function properly to begin with". other plaintiffs' attorneys questioned the constitutionality of taking away the plaintiffs' right to a jury trial. H. Martin Hunley, Jr., a New Orleans defense attorney, thought the plan could work if it were amended to allow litigants freedom to resort to the courts after a prescribed administrative hearing, other lawyers predicted that the proposed system would be very expensive]; see also Holzman, D. (1988, December 12). Malpractice crisis therapies vary. *Insight (Washington Times), 4,* 54–55 [He emphasizes the difference of opinions concerning medical malpractice remedies]

   Several states have shown strong interest in organized medicine's proposal, however. Vermont has introduced legislation to enact a close variation informed by organized medicine's basic plan in the 1990 and 1991 legislative sessions. Utah is readying legislation after an extensive self-study process. Michigan, a state operating through tort reform coalitions, has indicated interest after a decade's string of medical tort reform actions. Summaries of these developments are presented in *Insight into Courts, 1,* Nos. 1 and 2, available from the Program on Health, Science & Law, Georgetown University Medical and Law Centers, 219 Kober-Cogan Hall, Georgetown University, Washington, DC 20007.

3. While medical negligence adjudication and professional regulation traditionally have been "local" subject matter, lodged in the several states, new federal initiatives took form during the course of the Georgetown study of organized medicine's proposal for administrative adjudication. These initiatives provide both authoritative and financial impetus for demonstration of state level alternatives for medical tort reform. Most important of these developments has been the establishment of the new Agency for Health Care Policy and Research (AHCPR), established by Congress in December 1989 as the eighth and newest agency of the U.S. Public Health Service. AHCPR's mission is "to enhance the quality of patient care service through improved knowledge that can be used in meeting society's health care needs." See *AHCPR purpose and programs,* (1990, September). Public Health Service, U.S. Department of Health and Human Services; available from AHCPR, Parklawn Building, Room 18-12, Rockville, MD 20857.

   Most recently AHCPR began to set an agenda for federal support of medical liability research and demonstration. In February 1991, AHCPR convened a leadership conference in the nation's capital for that purpose. See *Issues in medical liability: a working conference* (1991, February), available from Kathleen Hastings, R. N., J. D., AHCPR. Results of the con-

ference are expected to be encompassed in research and development protocols for the federal government.

Moreover, the President's 1992 Budget urges nearly $1 billion in funds to support demonstration efforts related to federal health care programs. A 2-year study of tort reform needs, conducted by the Office of Management and Budget, resulted, in part, in waiver provisions in programs administered by the Health Care Financing Agency to demonstrate innovative new programs to reduce medical liability and promote health care quality. Such efforts can potentiate support for organized medicine's proposal.

Other calls for different approaches have been introduced at the federal level. In 1990, Representative Nancy Johnson (R-Conn), of the House Ways and Means Committee, introduced H. R. 4566, a bill that would mandate arbitration of Medicare cases, called "Medical Malpractice Dispute Resolution Act of 1990," 101st Congress, 2nd Session; Senator Orrin Hatch (R-Utah) introduced S. 2934, the "Health Care Access and Patient Protection Reform Act of 1990," which was referred to the Committee on Labor and Human Resources. The Hatch Bill, planned for reintroduction January 1991, is part of a comprehensive legislative package of bills to reform the health care system. It supports funding to the states for development and implementation of alternative dispute resolution systems programs in the medical liability area, including a fault-based administrative system; provides for other medical liability reforms, including limits on awards for non-economic damages, reducing awards by the amount of compensation from collateral sources, and limiting attorneys' contingency fees; strengthens the activities of state licensing and disciplinary activities; and improves state programs for educating state professionals.

4. However, it is clear that a research and demonstration project can be operated in the medical liability area, and that sufficient time, at least 5 years, is necessary to do so. The State of Maine, for example, enacted Public Law 931, which established a Five Year Medical Liability Demonstration Project that involves all sectors concerned with the topic and develops practice parameters for emergency medicine, obstetrics and gynecology, and anesthesia specialties. Safe harbors (affirmative defenses in tort and limited immunities in public policy) are created for liability claims brought against practitioners who agree to implement practice parameters adopted by the state's administrative procedures act. See Smith, G. H. (1990, October). "Maine's liability demonstration project—relating liability to practice parameters. *State health legislation report*. Chicago: American Medical Association. For other multi-year demonstration projects in Colorado and Minnesota, see *Issues in medical liability: a working conference* supra note 3.
5. On the other hand, critics may not put much stock in demonstration of the administrative alternative or other pilot projects. See Peters, J. D. (1990). Critique of the American Medical Association's model medical liability and practices reform act. *Courts, Health Science & the Law, 1*, 51–57. [He stresses the need for a limited test that could generate information on feasibility since, "without such evidence, to replace a system that has worked to resolve civil disputes for hundreds of years with an untried system that is radically alien to the citizenry is more than legally unsound. It defies common sense"].
6. This assessment's limitations are presented systematically in this report's section entitled, "Questions unaddressed by the study: limitations and a research and evaluation menu." In general, the study is burdened by its orientation, that is, a prospective assessment. The policy research literature generally terms such research as "meta-studies" and endorses them as a means to define the terms of natural or planned public policy experiments. See, generally, Gergen, K. J. (1968). Methodology in the study of policy formation. In Bauer, R. A., & Gergen, K. J. *The study of policy formation*, pp. 205–238. New York: The Free Press, Macmillan Books. The current assessment is subject to various elements of the methodological biases discussed but adopts the "formative" method prescribed for such prospective analyses. See, generally, Zweig, F. M. (1979). *Evaluation in legislation*. Los Angeles: Sage Books, especially Chapters 5–10. Also, see generally, Zweig, F. M., & Marvin, K. (1981). *Educating policymakers for evaluation*. Los Angeles: Sage Books, especially Chapter 1. As a theoretical bias, this current assessment impliedly adopts a group model of public policy making, that is, policy is a product of interactions among interest groups. For a more complete description of the group model and interest group theory, and other models, see Dye, T. R. (1978). *Understanding public policy*. Englewood Cliffs, NJ: Prentice Hall, especially Chapters 1, 14, and 15. For a normative orientation generally followed in the current assessment, see "Forward: health care as a laboratory for the study of law and policy," in Havighurst, C. C. (1988) *Health care law and policy: reading notes and questions*. Westbury, NY: Foundation Press.
7. For an overview of the types of criticisms leveled against the litigation system, see Metzloff, T. B. (1988) Researching litigation: the medical malpractice example. *Law & Contemporary Problems, 51*, 199–200. For a broad survey of the steps taken to reform the litigation system, see Ludlam, J. E. (1990 November and December). The real world of malpractice tort reform. *Journal of Health and Hospital Law, 23*, Nos 11 and 12.
8. Bovbjerg, R. R. (1990). Reforming a proposed tort reform: improving on the American Medical Association's proposed administrative tribunal for medical malpractice. *Courts, Health Science, & the Law, 1*, 19–28.
9. Harvard Medical Practice Study. (1990). *Patients, doctors and lawyers: medical injury, malpractice litigation and patient compensation in New York: the report of the Harvard Medical Practice Study to the State of New York*. Cambridge, MA: Harvard University (hereinafter referred to as "the Harvard study." [This study concludes that " . . . the tort system is providing very limited access to compensation for a large majority of patients who suffer negligent adverse events, and none for the much larger numbers who are injured due to no one's fault." Id. at 11-5. The study emphasizes that 1% of patients were negligently injured and that an additional 2.5% suffered adverse outcomes. It concludes that a no-fault medical compensation system is feasible and recommends a severely restricted universal method of compensation that would cost New York's medical liability cost center $894 million. The study is inconclusive about the deterrent effect of the current tort system and about the negligence-fortifying effect of a no-fault system. Id. at 11-8.
10. U.S. General Accounting Office. (1987). *Medical malpractice: a framework for action*, at 23. The costs, in turn, often hinge upon how much money plaintiffs' attorneys must "front"—advance—for each case. Some plaintiffs' attorneys now require an retainer and contingency fee agreements that certain costs be paid in advance by the client. The major costs for bringing suit, however, relate to payments to experts. Given the rising costs of expert witness examinations and testimony, some plaintiffs' firms appear to reject a case unless it is meritorious and the recovery is some multiple of the front costs. The GAO estimates may be low. In a private communication, Leonard Ring, then Chairman of the Torts and Insurance Practice Section of the American Bar Association, estimated in March 1990 that it is now common experience for plaintiffs' attorneys to assume initial costs for medical liability cases in the amount of $50,000 per case. Consequently, many plaintiffs' litigators are unwilling to accept cases if the estimated recovery is under $100,000.
11. See U.S. Department of Justice. (1986). *Report of the tort policy working group on the causes, extent and policy implications of the current crisis in insurance availability and affordability*: "because of the complexity of the issues, judges allow juries to hear medical views that may not be scientifically credible." (p. 13). Also see Institute of Medicine. (1989). *Medical professional liability and the delivery of obstetrical care*. Washington, DC: National Academy Press. [The study concluded that the traditional tort system is a slow and costly method of resolving obstetrical disputes and is contributing to the disruption of delivery care in the United States, and that both health care providers and patients have lost confidence in the use of the traditional medical tort system. It was recommended that states

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consider alternatives to the tort system for resolving medical malpractice claims."

12. See Daniels, S., & Andrews, L. (1989). The shadow of the law: jury decisions in obstetrics and gynecology cases. In IOM study report, volume II, supra note 1. [The report finds that only a small proportion of injury-causing medical errors leads to claims against the physician, and fewer result in a jury trial. If there is a jury trial, physicians usually win; awards may be high but are not excessive, given the seriousness of the injuries.]
13. O'Connell, J. (1986). Neo-no-fault remedies for medical injuries: coordinated statutory and contractual alternatives. *Law & Contemporary Problems, 49*, 126. See Relman, A. (1990, March 1). Changing the malpractice liability system. *New England Journal of Medicine, 322*, 626. See also Manuel, B. M. (1986). Professional liability—a no-fault solution. *New England Journal of Medicine, 322*, 627–631. See also, Reynolds, Rizzo, & Gonzales. (1987). The cost of medical professional liability. *Journal of the American Medical Association, 257*, 276; Rueter, J. A. (1984, November-December). Defensive medicine. *Congressional Research Service Review, 5*, 18–19, 30; Burda, D. (1987, April 5). Liability reshapes hospital/physician relationships. *61*, 56–60; Drummond, H. (1983, May). Over-preventive medicine: how doctors and lawyers are making mountains out of moles. *Mother Jones, 8*, 12–14, 16–17.
14. Priest, G. (1987). The current insurance crisis and modern tort law. *Yale Law Journal, 96*, 1521, 1582–484.
15. See Litan, R. E., & Winston, C. (Eds.). (1988). *Liability: perspectives and policy*. Washington, DC: Brookings Institution. [The report includes chapters on the following areas of tort law in which the insurance crisis has been most pronounced: medical malpractice, environmental liability, occupational liability, and products liability; and it summarizes policy recommendations. It concludes that stiffer regulation of the insurance industry would be counterproductive; that tort law would more efficiently deter undesirable behavior if judges encouraged juries, in deciding which parties should bear the costs of accidents, to balance the costs and benefits of the behaviors of the plaintiffs and defendants; that damage schedules should be established for pain and suffering awards; and that not enough is known about the costs and benefits of the current liability system to recommend replacing it with a government-administered compensation program.]
16. See Danzon, P. M. (1988). Medical malpractice liability. In Litan & Winston, supra note 15, at 101–127. After surveying broadly the tort reform field, the author concludes, "The search for cost effective reforms should focus on modifications of the tort system to reduce uncertainty and reduce inappropriate levels of compensation while retaining a fault-based rule of liability." Id. at 127.
17. Organized medicine's proposal argues in favor of the tort system—albeit a converted liability system, reformed and administered in a new institution—to achieve fairness for health care consumers and providers. The new agency would be modeled upon workers' compensation procedures but would apply fault concepts without limiting compensation.
18. The end result of the medical tort reform movement has been legislation in every state (only the District of Columbia has failed to enact medical tort reform) to smooth the way for doctors and patients to come to terms with medical negligence, medical liability insurance shortages, and a snarled judicial system. That legislation and the case law appended to it are succinctly summarized by Bannon, N. K. (1989). *AMA tort reform compendium*. Chicago: American Medical Association. Bannon summarizes state-by-state enactments regarding *ad damnum* clauses, arbitration, attorney fee regulation, collateral source rule, frivolous lawsuit penalties, joint and several liability rule, limits on recovery, patient compensation funds, periodic payment of damages, and pretrial screening panels. For another survey approach, see Spernak, S. M., & Budetti, P. P (1991). *Compendium of state systems for resolution of medical injury claims*. Agency for Health Care Policy and Research, U.S. Public Health Service, Department of Health and Human Services.
19. Johnson, K. B., et al. A fault-based administrative alternative for resolving medical malpractice claims, supra note 1, at 1376 ("These changes have been tried for over a decade in most states without resolving the crisis surrounding the availability and affordability of professional liability insurance"). "Neither consensus on goals nor good information on means is currently at hand," concludes Randall R. Bovbjerg in his 1988 survey of medical malpractice legislation, ADR, and insurance reform enacted in response to the medical liability "crisis" of the 1970s and 1980s. See Bovbjerg, R. R. (1989, Winter). Legislation on medical malpractice: further developments and a preliminary report card. *University of California at Davis Law Review, 22*, 556.
20. See O'Connell, supra note 13; Harvard Medical Practice Study, supra note 9. See also Sloan, F. A., & Bovbjerg, R. R. (1989). *Medical malpractice: crisis, response and effects*. Washington, DC: Research Bulletin, Health Insurance Association of America. [Legislatures have addressed statutory reforms for problems of insurance availability, medical quality, and tort reform, and it is tort reform that has received the most attention from legislatures and analysts alike. Some changes, such as the shortening of the statute of limitations, have resulted in reducing payments to claimants; however, the issue of fairness to claimants is still unresolved.] a general discourse on the advantages and disadvantages of alternative dispute resolution and alternate systems are in included in Nelson, L. J. (1986, Fall). Medical malpractice and alternative dispute resolution. *American Journal of Trial Advocacy, 10*, 345–363. However, the Model Act provides screening (determination of merit as well as valuation of damages) as an expert function procedure and a ministerial act of the state's medical practice review board. Its settlement-inducing activities are internal and subordinate, required through blind-offer settlement conferences. There is some suggestion that recovered compensation under *any* alternative system may be smaller than that surviving the litigation system through trial. See Note. (1983, Spring). Medical malpractice arbitration: a patient's perspective. *Washington University Law Quarterly, 61*, 125–156. Time and stress required may be substantially less, however, and valuation of payments awarded early has not been reported in the literature.
21. Johnson, supra note 19. Organized medicine's new, expert agency would be modeled upon workers' compensation procedures but would apply fault concepts without limiting compensation. The Harvard study championed a no-fault institution, based in part upon workers' compensation program templates, but achieving feasibility by limiting compensation to injury experienced after 6 months' duration. Presumably deaths induced by medical injury (13,000 of which were documented in New York in 1984) would be compensated by a uniform schedule. Early comparisons of the fault-based and no-fault systems have termed the former "a less drastic alternative" and the latter as resulting in reduction of "the enormous costs of defensive medicine" and much lower average awards. See Relman, supra note 13.
22. Tort Reform Codification, supra note 1, Model Act §202(a) and (b). During this initial stage, a physician may make a settlement offer but must notify the claims reviewer of the offer, at which time an attorney will be appointed by the Board to review the fairness of the offer on behalf of the claimant (§203(b)). In all instances in which the claimant has the option of retaining private counsel, compensation is limited to a set sliding scale of 40% of the first $50,000 recovered, 33⅓% of the next $50,000 recovered, 25% of the next $100,000 recovered, and 10% of any amount over $200,000 recovered (§205(b)).
23. Model Act §211(a)—(g).
24. This standard of review is modeled on the standard applied by courts to decisions by administrative agencies. See 5 USC 706 (1982).
25. See, e.g., Campbell v. United States, 325 F.Supp. 207, 210 (MD Fla. 1971).
26. The Board would be required to consider a variety of factors in making this reasonableness determination, such as any special expertise of the health care provider, the state of medical

knowledge, the availability of health care facilities, specialized equipment and personnel, and reasonable access to transportation and communication facilities. Similar to other administrative agencies, the Board will be given rule-making authority to implement statutory standards and requirements. The Board will exercise its authority in the manner prescribed by the state's administrative procedures act. The validity of any rule promulgated by the Board will be reviewable by the courts on the ground that it is arbitrary, capricious, or in excess of the Board's statutory authority.

27. See, e.g., Fitzgerald v. Manning, 679 F2d 341, 348 (4th Cir. 1982). See Havighurst, C. C. (1986). Altering the standard of care. *Law & Contemporary Problems, 49*, 265.

28. Caruso, A. (1990). The time present foundation of Maryland Medical professional regulation: recommendations for a better future. *Courts, Health Science & the Law, 1*, 251-262; Fellmeth, R. C. (1989, Spring). Physician discipline in California: a code blue emergency. *California Law and Regulation Reporter, 9*, No. 2; Committee on Small Business, Subcommittee on Regulations and Business Opportunities, U.S. House of Representatives. (1990, June 8). Testimony of Richard P. Kusserow on state medical boards and medical discipline; Inspector General, Office of Evaluation and Inspections. (1990, April). State medical boards and medical discipline. Washington, DC: U.S. Department of Health and Human Services; Simmons, N., McCarthy, P., & Wolfe, S. (1990, June). *6892 questionable doctors*. Washington, DC: Public Citizen's Health Research Group. [The Inspector General reported that case backlogs, as well as staff shortages, remain a serious problem for state medical boards. Moreover, although licensure renewal fees, which can serve as a major funding source for addressing these shortages, have been increasing, much of the revenue that state governments obtain from these fees has not been going to the boards.]

See also Model Act, §102. The Model Act specifies that the Board's seven members shall consist of three health care providers, at least two of whom shall be physicians, and four persons who are not health care providers. While health care providers are brought under the Medical Practices Review Board's claims adjudication jurisdiction, only oversight of physician performance is brought under its professional regulation authority. In reviewing complaints against physicians, the system is headed by a hearing examiner and overseen by a Board committee, comprised of two lay persons and one physician. Id. §300. One criticism of medical discipline has been its attention to issues not involving standard of care; and when substandard care is alleged, many states vaporize charges by providing insufficiently enumerated grounds for discipline. The Model Act specifies grounds in §301 and permits complaints from multiple sources in §302. Coupled with the statutory scheme's reversal of medical dominance, the Model Act channels toward fairness. Georgetown recommends that such channeling be perfected by providing legal assistance in citizen complaint filings against physicians. If that, or its functional minimum gatekeeping equivalent, were adopted, quality assurance ought also to be aided. The U.S. Office of Technology Assessment (OTA) has designated medical negligence incidents as a weak indicator of health care quality. It has designated medical discipline as a strong indicator. The Model Act's basic provisions incorporate many of OTA's observations. See U.S. Congress, Office of Technology Assessment. (1988). Disciplinary actions, sanctions, and malpractice compensation. In *The quality of medical care: information for consumers*, pp. 121-141. Washington, DC: U.S. Government Printing Office. [This overview study suggested that a large number of poor quality physicians are not identified or penalized. Pointing to the ineffectiveness of the existing system to identify those individuals providing poor quality care, it also stated that currently only a small percentage of disciplinary actions are based on incompetence, which is the ground that would most clearly indicate poor quality of care.]

29. Federal reporting requirements for claims under the Health Care Quality Improvement Act of 1986 through a medial liability clearinghouse began operation September 1, 1990, under authority of the clearinghouse provisions described in *Federal Register* (1989). 54, 42722-42734.

30. See Symposium: taking medical malpractice out of the courts (1990, July). *Courts, Health Science & the Law, 1*, No. 1. The papers were prepared by Randall R. Bovbjerg (consumer perspective), "Reforming a proposed tort reform: improving on the American Medical Association's proposed administrative tribunal for medical malpractice"; Mary Ann Baily (health economics perspective), "The administrative approach to medical malpractice disputes"; Laura L. Morlock (tort reform perspective), "An assessment of potential impact on claims resolution and the quality of medical care"; and J. Douglas Peters (plaintiff's perspective), "Critique of the American Medical Association's Model Medical Liability and Practices Reform Act." The commissioned authors presented the papers at a meeting of the project's Advisory Committee. For a summary of the Advisory Committee's discussions, see Turpin, S. D., Symposial papers deliberation: stakeholders evaluate a proposed administrative alternative for medical malpractice disputes at 46.

31. For the Wisconsin workers compensation case study, interviews were conducted with Greg Frigo, Administrator, Wisconsin Workers Compensation Division; David Birren, Assistant to the Administrator; Helen Schott, Head of Administrative Law Judges; Jim O'Malley, Administrative Law Judge; Jim Pflasterer, General Counsel, Labor and Industry Review Commission; Bill Cassel, Labor and Industry Review Commission attorney; Diane Ramthun, former administrative law judge; John Neal, plaintiffs' attorney; and Tom Gorner, defense attorney; as well as numerous clerical and support personnel from the Wisconsin Workers' Compensation Division.

32. Deleted in proof.

33. Deleted in proof.

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37. These surveys were presented in *Insight into Care* (1990, April and June), 1, Nos. 1 and 2. Aspects also were presented in *Courts Corner* (1990, July), *Courts, Health Science & the Law*, at 141-142.

38. See Note, supra note 20.

39. See Blendon, R. J., Leitman, R., Morrison, I., & Donelan, K. (1990, Summer). Satisfaction with health systems in ten nations. *Health Affairs, 9*, No. 2.

40. See Hale, J. P., & Ahlstrand, S. (1990, January). *General public opinion surveys conducted for the American Society of Cataract and Refractive Surgery*. Lincoln, Nebraska: The Gallup Organization, Inc., Association Research Group.

41. Georgetown University expresses our thanks to Professor Thomas Metzloff, Duke University Law School, for suggestions and assistance in drafting and interpreting this report section.

42. Dalkey, N., et al. (1972). *Studies in the quality of life*. Cambridge, MA: Lexington Books.

43. U.S. Congress, Office of Technology Assessment, supra note 28.

44. U.S. General Accounting Office. (1990, December). *Medical malpractice: few claims resolved through Michigan's mountain arbitration program. GAO/HRD-91-18*.

45. U.S. General Accounting Office. (1987, April). *Medical malpractice: characteristics of claims closed in 1984*. GAO/HRD-87-55. Washington, DC: GAO has estimated that the average disposition time of a medical malpractice claim in the tort system in 1984 was 25.1 months. GAO also found, using a random sample of malpractice claims filed in 1984 by 25 insurers (selected from a universe of 102 insurers representing every state and the District of Columbia, closing an estimated 73,104 claims), that the *median* disposition time was 19 months. The median disposition time for claims with an eventual payment of over $1 million was 56 months. Id. at 33.

46. See Program for Science and Law. (1990, March). Working paper: time and cost estimates. Washington, DC: Georgetown University, unpublished. See also Model Act, supra note 5, §202-211. Organized medicine's Model Act prescribed elapsed time limitations for some steps in the claims adjudicating mechanism and was silent as to others. Where it was silent,

Georgetown made estimates depending on the complexity of the case, through consultation with various experts in the field.

47. Jernigan, C. G. (1990). Step-flow diagrams of proposed medical malpractice adjudication and civil litigation. *Courts Health Science & the Law, 1*, 121-140.
48. Linde, A. E. (1990). *Arbitrating high stakes cases: an evaluation of court-annexed arbitration in the U.S. District Court*. Santa Monica, CA: Rand Institute for Civil Justice.
49. Working paper, supra note 46.
50. In Virginia, for example, pretrial screening panels were intended to eliminate litigation, according to a law journal article marking the reform's decennial anniversary. Settlement rates were not affected by a decade's experience, continuing at 90 to 95% of medical negligence cases filed in Virginia courts. See Daughtry, W. H., Jr., & Smith, C. H. (1985). Medical malpractice review panel in operation in Virginia. *University of Richmond Law Review, 19*, 272-298.
51. *Report of the Federal Courts Study Committee*. (1990, April 2). Philadelphia: U.S. Circuit Court of Appeals for the Third Circuit.
52. Marvell, T. (1987, October-November). Caseload growth—past and future trends. *Judicature, 71*, 151-161.
53. Zweig, F. M., Thurston, S. S., Turpin, S. D., Judge, D. C., Jernigan, C. G., Melnick, D. M., & Dougherty, C. A. (1990, April-May). Securing the future for America's state courts. *Judicature, 73*, 296-306.
54. The Conference on the Future and the Courts was held May 18-22, 1990, in San Antonio, Texas. Trends, scenarios, visions, and strategic plans were advanced by 380 invited participants over a 5-day period. Written summaries will shortly appear. Medical negligence and health care quality issues generally ranked in the upper quartile of expert opinions regarding the justice system's future. See, Zweig, supra note 53. Persons interested in the entire sweep of the conference may contact Dr. James Dator, the Conference's reporter, through the State Justice Institute, 120 S. Fairfax Street, Alexandria, Virginia 22314 (703) 684-6100.
55. Because most states do not routinely separate medical tort filings statistics from other torts or other civil actions, Georgetown asked the National Center for State Courts (NCSC) to cull its statistical system for those states that maintained such statistical distinctions. NCSC provided study staff with the following filing volume for selected states for calendar 1987: Arizona (Superior Court), 369; Connecticut (Superior Court), 512; Florida (Circuit Court), 1,813; Maine (Superior Court), 98; Massachusetts (Trial Court of the Commonwealth), 747; Minnesota (District Court), 377; New York (Supreme and County Courts), 7,926; North Dakota (District Court), 42. Georgetown then selected as its "typical" annual filings volume 750 cases as one element for agency cost calculations. Georgetown University extends its gratitude to Eugene Frango, assistant research director, National Center for State Courts, for his helpfulness and courtesy. Similar procedures were used to estimate a "typical" complaint volume against physicians. After reviewing state-by-state statistics, Georgetown assumed that the "typical" volume for purposes of the cost estimation for a proposed Medical Practices Review Board numbered 250 per year. The complaint volume assumption is based on the estimates of the Federation of State Medical Boards that, as a national average, one complaint is filed for every 40 physicians in the U.S. annually.
56. Georgetown staff estimated in several assessment project working papers that if a state were to pay attorneys at a rate of $90.00 per hour, legal fees alone could cost $10 million per year in a state with 750 new claims per year.
57. Georgetown estimated that, in a "low cost agency" (with a total annual expenditure of nearly $2 million) and in a "cadillac agency" (with a total annual expenditure of $7 million), the staff attorney annual costs would range between $423,000 and $2,722,500 for 15 and 25 lawyers, respectively. See Adjudication versus litigation: costs to state government. (1990, June). *Insight into Courts, 1*, No. 2, Table 3, "Organization cost estimates for model act implementation (in 1989 dollars)," at 6.
58. Cost assumptions for the administrative agency's estimates are published. See *Insight into Courts* (1990, June) *1*, No. 2, p. 6. Customary and typical cost centers were attributed to the agency, and totals were assumed to represent annual operating costs. These totals generally found corroboration in budgets & characteristics of Maryland's Health Claims Arbitration Office and Bureau of Medical Quality Assurance. See Thurston, S. S. (1990). Medical malpractice dispute resolution in Maryland. *Courts, Health Science & the Law, 1*, 81-86. Budget and audit histories of the Wisconsin Division of Workers' Compensation and the Wisconsin Securities Commission also corroborate the ballpark utility of Georgetown's cost estimates. For example, for staff of a size and composition comparable to the proposed Medical Practices Review Board, Wisconsin's workers' compensation annual budget in 1988 was $4.2 million. see U.S. Department of Labor (1990). Workers compensation agency information: a state-by-state comparison, unpublished. Georgetown's estimates range from $2 to $7 million for the proposed new medical practice agency. The extremes represent a "low cost" and a "high cost" alternative, respectively.
59. (Maryland) Thurston, supra note 58, at 81; (Virginia) Klaidman, S. (1990). Medical malpractice in Virginia. *Courts Health Science & the Law, 1*, 75-80; (Michigan) Thurston, S. (1990). Medical tort reform: the Michigan case. *Courts Health Science & the Law, 1*, 263-271.
60. Caruso, supra note 28.
61. Morlock, supra note 30.
62. Michigan, for example, has offered claimants the option of electing mandatory binding arbitration for medical negligence claims, and as noted in note 27, the arbitration act was tied up in litigation for 9 years before the Michigan Supreme Court finally declared it to be constitutional. During the period of uncertainty, very few cases elected arbitration. Presently, about 6.2% of the medical negligence cases in Michigan elect arbitration; the larger cases tend not to elect arbitration. See Applied Social Research, Inc. (1983, October). Evaluation of Michigan Medical Malpractice Arbitration Program. Likewise, in Maryland, the Health Claims Arbitration Act [establishing mandatory non-binding arbitration] was passed in 1977 and declared constitutional in 1978. In 1977, only two cases were filed at all; the next year, 93 cases were filed. Case filings peaked at 749 in 1986 and have leveled off to about 500 per year. See Thurston, supra note 59.
63. U.S. General Accounting Office, supra note 44.
64. It might be possible to experiment with the jury system, but current system proponents might more strongly object to such innovation as a direct constitutional assault than that posed by the pilot test of an administrative alternative. See Pendell, J. W. (1989). Enhancing juror effectiveness: an insuror's perspective. *Law & Contemporary Problems, 52*, 311.
65. See *Public attitudes toward the civil justice system and tort law reform*, study no. 864014. (1987, March). New York: Louis Harris and Associates, Inc. [A survey of almost 2,130 adult Americans showed that almost 9 of 10 Americans want changes in the civil justice system. The Harris report on this survey stated, "what most of the public currently demands is greater efficiency at a lower cost to both individuals and society."] See also Swickard, J. (1986, August 7). Survey finds most feel justice is costly, complex. *Detroit Michigan Free Press*.
66. Georgetown's research staff is grateful to Professor Thomas Metzloff for the articulation of this dilemma. The following observation extends themes begun in his earlier, important article. See Metzloff, supra note 7.
67. For a useful, albeit dated survey of challenges to extrajudicial arbitration of health care injury claims, for example, see Sanders, L. K. (1986, Winter). The quest for balance: public policy and due process in medical malpractice arbitration agreements. *Harvard Journal on Legislation 23*, 266-285. Challenges may be raised against entry of all extrajudicial organizations. In Maryland, for example, the Health Claims Arbitration Office, an executive branch agency, weathered a series of such challenges. See Thurston, supra note 58.
68. Inspector General, supra note 28.

69. Caruso and Fellmeth, supra note 28.
70. Jernigan, supra note 47.
71. Organized medicine's proposal, supra note 1, p. 14, states that "in making this proposal, we are not breaking new ground. State legislatures abolished the common law cause of action for personal injury in the workplace just after the turn of the century. In its place, states enacted workers' compensation schemes—based upon a quid pro quo deemed to serve all parties' interests." See infra note 72.
72. A recent Virginia case, Roller v. Basic Construction Co., ——— VA ———, 384 SE 2nd 323, 325 (1989), explained the quid pro quo as follows: "As frequently stated, the Workers' Compensation Act is based upon a quid pro quo, a societal exchange wherein employees are provided a purely statutory form of compensation for industrial injuries. The remedy is modest, but relatively certain. Claimants are free from the necessity of proving negligence and resisting such affirmative defenses as contributory negligence and assumption of risk. In exchange, employers under the canopy of the Act are sheltered from common-law liability in tort."
73. For a discussion of constitutional issues in workers' compensation cases, see generally Cudahy Packing Co. v. Parramore, 263 US 418, 44 SCt., 153, 68 LEd. 366 (1923); Arizona Employers' Liability Cases, 250 US 400, 39 SCt. 553, 63 LEd. 1058 (1919); Jensen v. Southern Pacific Co., 215 NY 514, 109 NE 600 (1915), reversed on other grounds 244 US 205, 37 SCt. 524, 61 LEd. 1086 (1917). Also see Boden, L. I. (1988, December). Reducing litigation: evidence from Wisconsin (WC 88 7). Cambridge, MA: Workers' Compensation Research Institute.
74. See, for example, Kladiva, S. D. (1988, Spring). The clash over medical malpractice. *GAO Journal, 1*, 48-54. [She states that policy makers will not be successful in enacting malpractice legislation and reforms until the problems of inadequate data, conflicting objectives of the parties, and the crisis environment in which malpractice reform is attempted are alleviated; see also Sloan & Bovbjerg, supra note 20, at 45.] [They predict a possible liability crisis in the not too distant future and encourage policy makers to react as part of a reasoned approach to compensating and deterring injuries, not in a crisis management style.]
75. Learner, H. A. (1981, Winter). Restrictive medical malpractice compensation schemes: a constitutional "quid pro quo" analysis to safeguard individual liberties. *Harvard Journal on Legislation, 18*, 143-206. [The author argues that utilizing the intermediate level of scrutiny to examine the constitutional integrity of restrictive medical malpractice compensation schemes is inadequate and that the same quid pro quo analysis utilized in workers' compensation schemes should be utilized instead.]
76. Gurtler, P. R. (1989, Fall). The workers compensation principle: a historical abstract of the nature of workers compensation. *Hamline Journal of Public Law and Policy, 9*, 285-296. See also Larson (1952). The nature and origin of workers compensation. *Cornell Law Quarterly, 37*, 206; Hood, J. B. & Hardy, B. A., Jr. (1984). *Workers compensation and employee protection laws: theories and policies of workers compensation*, pp. 23-32. St. Paul, MN: West Publishing Co.; King, J. R., Jr. (1988). The exclusiveness of an employee's workers' compensation remedy against his employer. *Tennessee Law Review, 55*, 407; Bale, A. (1989, Winter). The enactment of the state workers' compensation laws in American legal studies. *Legal Studies Forum, 13*, 49-73.
77. The fault context is believed by organized medicine to retain the profession's historical and ethical responsibility for patient care. No-fault systems would likely be easier to sustain constitutionally, and Reynolds and co-authors do not try to discredit them even though jury trial is unavailable. For many observers, no-fault uses an economic approach that considers the cost of accident prevention and the cost of the harm. The moral connotation of fault is eliminated, but so is the responsibility for professional action. The economic theory is presented in Judge Learned Hand's famous case, TJ Hooper, 60 F2nd 737 (1932). The practice of health care provision goes beyond such theories, however, and affects real people proximately and profoundly.
78. U.S. General Accounting Office, supra note 44.
79. *Report of the Federal Courts Study Committee*, supra note 51.
80. Id, at 18-19.
81. Id.
82. See Zweig, et al., supra note 53.
83. Id. at 303.
84. Bovbjerg, supra note 8.
85. Inspector General, supra note 28.
86. *Federal Register*, supra note 29.
87. Georgetown's research staff is grateful to Professor Thomas Metzloff for the articulation of this observation.

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EXECUTIVE SUMMARY

Georgetown University undertook between 1989 and 1991 six small-scale studies to illuminate organized medicine's proposal for a new fault-based administrative agency at the state level to adjucate medical negligence claims and relate such adjudication to medical professional oversight.

The key element in this proposal is the creation of a "Medical Review Board" appointed by the Governor with the concurrence of the state legislature. This Board would replace common law courts as an exclusive, mandatory remedy for health care consumers who believe they have a claim against a health care provider. A primary objective is to provide claimant access to a predictable, prompt, expert system of dispute resolution and compensation. Its primary means to achieve that objective is free, guaranteed legal representation furnished claimants by the proposed Board. Once the various steps in this proposed system are exhausted, an appeal is available to a state appellate court, but the latter's jurisdiction would be confined to a determination of whether the Board adhered to the rules and not whether the decision was correct.

The mini-studies undertaken by Georgetown were intended to answers several questions raised with respect to organized medicine's proposal. The fairness and efficiency of the proposed administrative system when compared with the current system of civil litigation has been posed as a principal question. Its cost and ability to marshall scientific evidence effectively

was also questioned. A final inquiry is the utility of workers' compensation agencies as an adjudication prototype.

The results of studies led Georgetown to conclude that the new institution proposed by organized medicine could be as fair and would be more efficient than the system of current litigation. Moreover, it has the potential to improve health care quality generally through linkage of medical negligence adjudication and professional discipline. A summary of the mini-study findings follows below.

Fairness

Organized medicine's proposal would enhance fairness for plaintiffs in the resolution of medical negligence disputes even though the proposed new administrative agency would dispense with jury trials. Fairness would be enhanced in large part from the provision of free legal representation built into the proposed new institution. A major problem facing health care consumers is blocked access to the legal system, especially for persons having meritorious small claims, i.e., those under $100,000. The new administrative agency would provide such access. To assure both fairness and its perception, Georgetown recommends that organized medicine's proposal assist claimants in the initial preparation of a claim and that the agency's staff lawyers be insulated from chain of command requirements that typically are a part of administrative schemes. There is every reason to believe that such minor amendments could easily be made.

Time and Cost

Georgetown's mini-studies disclosed that as much as half the time currently required to resolve medical negligence disputes would be required for administrative adjudication of typical claims. For claims of profound and severe medical injury, the administrative agency would require approximately 20% less time than currently experienced on average in the civil justice system.

Costs

Georgetown found that the cost to the public of maintaining a forum for medical negligence adjudication would be approximately 25% less per case than the cost of operating the courts in such cases. At the same time, such reduced costs permit payment of free legal representation to claimants. Thus, it was concluded that a fault-based administrative agency could be one of the best public policy "bargains" to emerge in the health field.

Georgetown also concluded, from studies of state medical board financing and operation, that a fault-based administrative agency could be operated at approximately the same cost level requirements as medical credentialing and disciplinary agencies.

Expert Opinion

One of the mini-studies conducted in the Georgetown review was a "Delphi" study of 29 experts representing the entire spectrum of plaintiff and defendant orientations. This mini-study asked for elaborate written responses to organized medicine's proposal. The written response was followed by a lengthy personal interview.

The 29 experts determined that the administrative agency, in their opinion, would be more efficient than the current system. They also concluded by a majority opinion, 60% to 40%, that it would be less fair, although the basis for fairness, aside from abolition of jury trials, was unclear.

The experts believed that a demonstration test of organized medicine's proposal should be conducted. Nineteen states were suggested as possible candidate test sites.

Judicial and Court-Related Opinion

In several separate surveys of judges and court-related personnel, opinion about the desirability of organized medicine's central premise was evenly divided into thirds. When asked whether medical negligence cases should be relocated to an administrative agency with guaranteed claimant legal representation, one-third favored the idea, one-third opposed it, and one-third were neutral.

In view of the strong trend set by the Federal Courts Study Committee to promote experimentation with dispute resolution, the environment for organized medicine's proposal seems to be considerably more favorable for a pilot test than at any time in the past.

The Workers' Compensation Analogy

Georgetown undertook a thorough study of the workers' compensation agency in Wisconsin, generally considered to be among the best of such operations in the United States. Organized medicine had proposed that the new fault-based administrative agency would be modeled after workers' compensation agencies. Georgetown found that the workers' compensation system is a useful analogy; it is an efficient and fair mechanism; and it enjoys widespread support in that state. Private attorneys in the program are willing to accept the 20% of claimant cap imposed upon claimant awards in exchange for caseload volume, one feature of organized medicine's omnibus proposal as regards permissive retention of private counsel by claimants.

Unexplored Issues and Suggested Improvements

The constitutional implications of shifting adjudication to administrative experts from a jury trial forum—from Article III to Article I courts—remain unexplored. It may be that real access to an authoritative dispute resolution system for the 7 out of 8 medically injured people with relatively small claims, who are currently locked out of the courts, is the necessary quid pro quo to achieve that shift.

The centerpiece of that access is universal, free legal representation, provided as a right to anyone with a claim against a health care provider. To foster access, organized medicine should consider providing such representation from the time a person drafts a claim, not from the time, as currently proposed, a claim is certified as meritorious. Moreover, the plaintiff's bar should be brought into an experimental design, perhaps with cases allocated on a lottery basis, and outcomes should be compared with cases handled by Board-employed attorneys.

Organized medicine's new institutional design promises many advantages leading to improved health care quality. Its built-in connection of adjudication and professional performance oversight is one such advantage.

The proposal may well be a way to go beyond a truce and to bring collaboration between medicine and justice.

Appendix F

The AMA Response

The AMA together with the more than thirty national medical specialty organizations which participate in the AMA/Specialty Society Medical Liability Project, is actively working to further the goal of patient safety. Among its purposes, the AMA/SSMLP is dedicated to furthering innovation in the loss prevention field and has a standing Patient Safety/Risk Management Subcommittee. Through this Subcommittee, the AMA/SSMLP monitors patient safety initiatives and disseminates information to hospitals, medical societies, insurers and others to promote the exchange of ideas and approaches.

The AMA/SSMLP also has undertaken development of several practical risk management tools. In 1988, it published, together with the PIAA, the Compendium of Patient Safety and Medical Risk Management Programs, a 160 page catalog of the risk management activities of state and national medical societies, insurers and others, complete with subject matter index and the identities of key contact people to facilitate networking among professionals across the country.

This initial contribution was followed with a document entitled Principles and Commentaries on Risk Management for the Medical Office. Developed in consultation with nationally known experts, the publication sets forth in twelve chapters pragmatic risk management advice primarily for office-based practices. The chapters cover such topics as obtaining informed consent, establishing good communication with patients, developing workable follow-up systems for responding to patient telephone calls and missed appointments, instituting schedules for the maintenance and calibration of equipment and evaluating the safety of office and parking area grounds, among others. (Copies have been provided to the Subcommittee members.)

The AMA/SSMLP also is implementing an integrated risk management program that already has been pilot tested in Oregon. Based on principles of continuous quality improvement, the program's two-fold purpose is to offer risk prevention advice and collect data to be used as a continuous feedback mechanism on the effectiveness of loss prevention efforts. The program consists of an office self-assessment survey, a self-study course and an office site visit and assessment by a professional risk manager -- which together constitute a single learning process that is adaptable to any specialty.

In addition to these activities, in January of this year the AMA published a risk management resource book developed for residents and young physicians that was developed in conjunction with the Harvard Risk Management Foundation. Entitled Grand Rounds on Medical Malpractice, the text is now being used by the Harvard Medical School, and is also available as a CME risk management course for practicing physicians.

These targeted injury prevention efforts represent only a few of the many activities undertaken by the Maine Medical Association, the AMA and

others to continually improve the quality of medical care. In 1986, the AMA began a major initiative to expand its traditional leadership and reaffirm the profession's commitment to self-regulation. As part of this initiative, the AMA established in 1987 a new Office of Quality Assurance to promote the development of practice parameters that address effective clinical practice and appropriate utilization. The AMA's quality assurance activities are outlined in the Association's Health Access America proposal.

Most recently, the AMA has initiated a program to review its membership on a continuing basis and withdraw the privilege of membership from those physicians who have been found to be incompetent or unethical. In January, 1990, a commitment was made to assist any state or county medical society to take similar action. This commitment includes providing guidance on the appropriate procedural steps and safeguards that must be followed, and paying the litigation expenses incurred by medical societies or their members in discharging this responsibility -- a factor that has chilled action of this nature in the past.

We recognize that this latest action does not eliminate the danger posed by the small population of aberrant practitioners that threaten the safety of their patients. We offer it as one more affirmative step in a continually expanding effort to minimize this danger wherever possible.

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PREPARED STATEMENT OF SENATOR JOHN D. ROCKEFELLER IV

Resolving the issue of medical liability is a critically important step towards reforming a bloated and ineffective health care system. It cuts across all aspects of our health care system.

When doctors protect themselves by ordering unnecessary tests, costing our health care system $25-75 billion a year, our health care system and our economic health are affected—and seriously.

When physicians use outdated treatments or are careless and patients are harmed, our citizens and our health care system are affected—and seriously.

When a women can't get prenatal care because stratospheric malpractice premiums and fear of frivolous lawsuits have driven her hometown obstetricians to stop delivering babies, both our children and our health care system are affected—and seriously.

Medical liability reform is not a problem for just doctors and lawyers to be concerned about. It's an issue that affects all of us, an issue we should learn more about. And though several of my colleagues have introduced medical liability reform legislation, I'm sure they could also benefit from hearing a bit more on this topic from experts.

There is no question that our entire health care system is in need of extensive systemic reform. This committee and other committees have held several hearings on many aspects of our health care system for which significant data exists, allowing us to carefully define the problems and begin to propose solutions.

Liability reform may be a part of the solution. But it is by no means a solution in and of itself. The Vice President and the Bush Administration are touting tort reform to a weary public as the single medicine that will cure the many ailments our health care system suffers. As politically appealing as attacking lawyers is, this approach will not by itself dramatically cut costs, or save lives. It cannot be allowed to obscure the many other difficulties true health care reform must overcome.

This committee has addressed a number of different issues, hearing testimony on: the uninsured and how to provide universal access to care; the costs of medical care and how to control them; and the evaluation of the quality of care in our system and how we can improve on it to get the absolute best care possible for our citizens.

Unlike some of the other concerns regarding our health care system, this issue has not had extensive public review and scrutiny. Further, although virtually no one is happy with our current system, the data regarding the exact nature of the problem and its impact on health care delivery in America is less well understood.

I hope that as a result of this hearing we will have some answers to the following questions: Should the federal government be involved in what is traditionally the bailiwick of the states? How common are negligent injuries to patients and are they fairly compensated for their losses? What effect, really and truly, does the current medical liability system have on the delivery of health care by doctors and other providers? How often are unnecessary tests ordered and what are the consequences for patients, who are subject to them—for business, who is being asked to pay the bills—and for our country, as we are being crushed by health care spending?

Most importantly, I want to learn what we can do to change the system to avoid adverse outcomes entirely, by *preventing* them rather than *compensating* for them. This is why I called this hearing today and that is what I hope we can accomplish this morning.

PREPARED STATEMENT OF DANINE A. RYDLAND

Mr. Chairman and Members of the Subcommittee, I am Danine A. Rydland, MD, an obstetrician-gynecologist from Martinsburg, West Virginia. This is the second time I have testified before the U.S. Senate, the first time was in 1986. At that point my liability insurance premium had just increased to $13,241, at 400% increase. I implored the Senate to take action before physicians like me were forced out of practice.

In 1986, I could not have believed that I would be back before the Senate in 5 years. I could not have believed that I would be forced to give up my obstetrics practice in 1990, since my malpractice insurance premium was rising to $40,000 but would be only $17,500 if I limited my practice to gynecology. Given the economic situation in West Virginia, I could not pass these costs along to my patients; they simply could not pay them. And lastly, I could not have believed in 1986 that I would appear again before the Senate without the passage of a single piece of federal legislation to address this problem. Perhaps I was just young and optimistic.

But the major problem is not mine nor even that of the 12.2% of my obstetrician-gynecologist colleagues who have given up the practice of obstetrics due to malpractice concerns. The biggest problem is for the patients who must drive farther for obstetric care, those who have difficulty finding an obstetrician-gynecologist to treat their high-risk pregnancy, and those for whom obstetric care is unaffordable because of liability premiums. It is also a problem for our patients who are injured while receiving health care. Under our current system they must cope with an adversarial system and wait a long time for compensation, if it is ever received, an average of almost 5 years from the time an incident occurs.

Let me tell you about these problems in a little more detail and suggest what you can do to address them.

THE PROBLEM

The liability crisis is having a major impact on obstetrician-gynecologists and the patients they see. While many physicians have liability problems, few physicians face the extremes that obstetrician-gynecologists do. The 1989 average professional liability premium of $38,138 is considerably higher than that of physicians in general. Regional variations are also large. Obstetrician-gynecologists in ACOG's District II, which consists of the state of New York, report an average premium of $62,626 and those in Florida $51,634. And don't forget even in a small, rural state like West Virginia my premium would be $40,000 if I was doing obstetrics.

Almost 78% of the Fellows surveyed by ACOG in 1990 had at least one professional liability claim filed against them. This was a significant increase from the 70.6% reported in 1987. And more obstetrician-gynecologists are experiencing multiple suits. For example, by 1990, 36.6% of Fellows had been sued three or more times. In New York and the Mid-Atlantic states (Pennsylvania, New Jersey and Delaware), more than half, 51.2%, of ACOG Fellows had been sued three or more times.

If medical care was getting worse, the liability crisis would not be surprising, but all indications for the last decade show better outcomes. Infant mortality rates are down, maternal mortality rates are down, yet the number of lawsuits is up.

As a result of these and other liability problems, 12.2% of obstetrician-gynecologists nationally have given up obstetrics and 24.2% have decreased the amount of high-risk obstetric care that they provide. As I discussed earlier, one factor in the decision to discontinue obstetrics is that the liability premium for gynecology alone is substantially less in many areas. The 1991 rate for physicians practicing only gynecology in Broward and Dade Counties in Florida is $67,500. Those who also practice obstetrics pay $149,000 or 121% more. Obstetrician-gynecologists pay 88% more in Idaho, 89% more in Hawaii, and 98% more in Arizona, than their counterparts who practice only gynecology.

Taking a closer look at those Fellows who discontinue obstetrics due to the risk of professional liability reveals another disturbing trend. Our 1990 survey shows that 36% of those who had quit obstetrics had stopped before the age of 45 and 61.9% by the age of 55. These numbers have increased from 25% and 50%, respectively, as reported in 1985. Traditionally, obstetrician-gynecologists phase out their obstetric practices as their patient population ages and make a normal transition to a gynecology-only practice around the age of 55. With so many of our Fellows discontinuing obstetrics before that age for liability reasons, it is clear that we are losing some our most experienced and competent practitioners.

The obstetric liability crisis also affects family physicians and their patients. For example, in Florida, family physicians whose practice includes more than 25 deliveries per year pay the same medical liability insurance premium as obstetrician-gynecologists. One-third of family physicians in California whose practices had included obstetric services, no longer provide obstetric care. Almost 40% of Texas family physicians and approximately one-half of Nevada's rural family physicians have stopped delivering babies.

Looking at the combined numbers for obstetrician-gynecologists and family physicians is also illustrative. A 1987 Oregon survey shows that the number of physicians delivering babies has declined by 25% since 1984. A 1987 Iowa survey shows that of all physicians who had provided obstetric services since 1981, 31% had discontinued obstetrics; half of them had practiced in rural areas.

It was information like this that led an Institute of Medicine panel to conclude that a problem exists. In the words of the panel chairman, "the professional liability problem adversely affects the delivery of obstetrical services, especially to disadvantaged women, those living in rural areas, and those with high-risk pregnancies. Moreover, the liability problem compromises the therapeutic value of the relationship between providers and patients, alters—often without medical justification—the types of care given, and adds to the costs of obstetrical care.

Some attribute the liability problems to lawyers, or insurance carriers, or bad doctors, or to the public's expectation of perfection. We have learned that this is a complex problem and no one group is solely to blame. The solution lies in efforts by everyone. For example, it is difficult to allege avarice on the part of insurance companies when more than 50% of physicians are insured by non-profit physician-owned companies whose premiums are comparable to those charged by commercial carriers. Nor can it be assumed that the problem has arisen solely from contentious attorneys. However, both the insurance industry and the legal profession must accept responsibility to be part of the solution. With the amount of publicity given to "medical miracles," one can understand the public expectations of perfection. But perfection is an unrealistic goal in medical practice. Less than perfect outcomes occur even when no negligence exists. The tort system was not intended to compensate for injuries absent negligence, yet more and more damages are being awarded when the presence of negligence is questionable at best.

The "bad doctor" is also blamed by some for the current crisis. The fact that 77.6% of our Fellows surveyed have been sued indicates to us that virtually no one is immune from the threat of a lawsuit, no matter how well qualified or conscientious. While the facts do not demonstrate that incompetent or impaired physicians are primarily to blame for the current crisis, the College supports efforts to strengthen the process for removing these physicians from the practice of medicine as a realistic effort to improve quality. State licensing boards have the authority to remove these physicians from patient care and must be given adequate resources to do so.

ACOG EFFORTS

We at ACOG have not stood idly by while the situation has gotten worse. Rather, ACOG engages in numerous activities to assure the quality of care and to address the liability problem. The practice of medicine is constantly changing and ACOG serves as a major source of information to Fellows on the delivery of the most appropriate medical care. ACOG publishes many documents to keep Fellows informed, including standards and guidelines for care, and technical bulletins on specific subjects and procedures. We provide a number of scientific meetings, 15 post-graduate courses, nine regional meetings and a national clinical meeting each year. A variety of printed and taped educational tools are also available. One of the newer initiatives is the ACOG peer review project designed to assist hospitals in assessing the quality of obstetric and gynecological care being provided Upon a formal request from a hospital, the College will make available a team of qualified obstetrician-gynecologists specially trained to conduct site visits to review clinical performance in our specialty and to consider any specific problems brought to its attention by hospital authorities. The team will spend two to three days on site and will prepare a final report setting forth its findings and possible options for action. Through this approach, ACOG can provide independent, outside review when a problem or potential problem exists that is difficult to resolve at the hospital level.

Eight years ago, in attempt to better understand the liability problem, ACOG became the first medical specialty society to establish a department of professional liability. That department serves as a resource to Fellows of the College and to the public on professional liability issues, providing up-to-date information on professional liability insurance and educational materials on the legal system and risk management. As mentioned earlier, in 1983 and biennially thereafter the College conducted surveys of the membership to determine the effect of professional liability on the provision of obstetric care. The department also works with other organizations, both medical and non-medical, to develop programs to alleviate the liability crisis. We have worked with attorneys and insurance carriers to understand better the dynamics between the quality of medical care rendered, the frequency of lawsuits, the size of award or settlements, and the rate of insurance premiums.

FEDERAL ROLE

For years, federal legislators have responded to problems in professional liability by saying that the crisis must be addressed in areas traditionally left to the states—establishing rules for tort actions and regulation of insurance. Most states have enacted changes in their tort laws over the past decade. Despite some success through state enactments of reform, not all states' efforts have been effective and most still have serious liability problems. A national liability crisis is a reality.

The individual states can no longer deal with this problem. In the field of medicine, doctors are increasingly held to national standards of care. It is time for the national leadership to assert its role and address the tremendous liability problems

facing this country. ACOG looks to the Congress for help in solving the recurrent liability insurance crisis and the resulting threat to continued access to high-quality maternity care for the women of this country.

The federal government through Medicare, Medicaid, Champus and other programs provides health care for many citizens. The liability crisis affects the cost and access to such health care. Given the fact that the federal government pays nearly 40% of the nation's health care expenditures, it is inappropriate for the Congress to ignore a major problem affecting costs and access to this care.

Senators have begun to recognize the need for federal involvement in liability issues and have introduced legislation to deal with the problems. The College is particularly encouraged by S. 489, S. 1232, and S. 1836.

TORT REFORM

As we have already stated, we strongly support a federal role. One role that we believe the federal government should play is to establish certain minimum rules for tort awards. Specifically, we believe that a cap on noneconomic damages, periodic payments of future damages, a shortened statute of limitations for claims by minors, and a mandatory collateral source offset would be beneficial. The President, in his medical liability reform proposal, has supported similar tort reforms.

ACOG believes the collateral source rule, which prohibits the defendant from introducing evidence that the plaintiff has received payment for losses from another source, should be eliminated and replaced with mandatory offset against awards for compensation received from other sources. The collateral source rule allows plaintiffs double recoveries since they can recover from government or private insurance companies and also in tort. To the extent that injuries are compensated more than once, insurance costs for all are increased.

Periodic payments provide another way to reduce the costs of liability actions without preventing the plaintiff from receiving a fair recovery. If the tort award for future damages is paid out over time rather than all at once, both the plaintiff and defendant benefit. The plaintiff is assured that money will be there when it is needed and the defendant's payout is made more predictable.

A cap on noneconomic damages, such as pain and suffering, has been an element in effective tort reform at the state level. This type of cap does not limit in any way recovery for economic losses, such as medical care or lost income. However, it does limit what could otherwise be unlimited recoveries since noneconomic losses are difficult to quantity, as well as to insure for. This type of legislation is a reasonable approach since the plaintiff still receives full compensation for economic damages. ACOG supports provisions of S. 489, S. 1232, and S. 1836 which establish a $250,000 cap on noneconomic damages.

In addition, shortening the statute of limitations for minors is important to obstetrician-gynecologists. In some states the period in which a suit can be brought extends beyond the age of majority. For an alleged injury at birth, actions can be brought in such states after more than twenty years. Such cases are obviously difficult to defend. Even good memories fade after twenty years, the whereabouts of all relevant parties may not be known and medical practices may have changed dramatically.

These reforms are similar to those that have been enacted in California. Data from our 1990 survey indicates that the effect of these reforms goes beyond' saving money. For example, while 12.2% of the respondents nationally have given up obstetrics because of malpractice risks, only 9.4% of California respondents have. The 1990 survey also shows a significant increase in the percentage of California obstetrician-gynecologists devoting at least one-fifth of their practices to high-risk care.

ACOG strongly encourages this Committee to report legislation establishing these tort reforms as federal law. While the ACOG supports such efforts, we are convinced the problem will not be fully resolved until alternative dispute resolution systems are available. The current system for compensating injured parties is time consuming, frequently resulting in delays of 2-5 years in receiving payment. It is also inefficient, with as little as 28% of the premium dollar being received by the injured parties. We contend that a system which returns so little of the premium dollar to the injured party and which requires so much time for the settlement of disputes is unacceptable.

ALTERNATIVE DISPUTE RESOLUTION SYSTEMS

S. 489, S. 1232 and S. 1836 all have provisions that would utilize alternative dispute resolution systems. The Institute of Medicine report mentioned earlier supports federal grants to the states to encourage them to experiment with the alterna-

tive dispute resolution systems. S. 489 and S. 1836 would do exactly this. S. 1232 would establish an alternative dispute resolution system for care paid for by the federal government and that paid for with dollars for which a federal tax deduction will be received. We desperately need an alternative to the tort system and enactment of these bills would help us to establish one.

QUALITY OF CARE

While ACOG does not believe the liability crisis results from the bad doctor, we support efforts to remove physicians who provide substandard care from the practice of medicine. Strengthening the role of the state medical boards is one way of accomplishing this. We support including provisions to strengthen the state medical boards in medical liability reform legislation.

COMMUNITY AND MIGRANT HEALTH CENTERS

Commnnity and migrant health centers provide an important source in many areas where critical services, like maternity care, would otherwise be unavailable. Unfortunately, liability premiums are eating up precious dollars that would otherwise be available for patient care. Given the large portion of their dollars that come from the federal government, addressing their problem is critical. S. 489 and S. 1836 have provisions to do this.

CONCLUSION

It has never been safer for a woman to have a baby in the United States than today. And it has never been more risky for a doctor to deliver one. Today more and more physicians are discontinuing obstetric practice because they are unable or unwilling to pass on the high costs of liability insurance to their patients Pregnant women in many areas of the country are having difficulty obtaining prenatal care. There is an increasing tension and growing distrust between patients and physicians. None of these developments contribute in a positive way to the healing process. I urge you to pass federal legislation. With all due respect, I would rather be treating patients as I was trained to do, than be here testifying. I hope that if I'm called upon to testify 5 years from now, it will be to tell you the positive effects your legislation has had on the delivery of obstetric care, and not to tell you how much worse the situation has gotten.

PREPARED STATEMENT OF RICHARD I. SMITH

I. Introduction

Good morning. I am Richard I. Smith, Public Policy Director of the Washington Business Group on Health (WBGH). WBGH is an organization of Fortune 500 employers that has been involved in public- and private-sector efforts to improve health care delivery and financing since 1974. I appreciate the opportunity to discuss medical malpractice liability with you today.

WBGH is nearing completion of a formal position on malpractice reform. However, in line with this hearing's purpose of gathering information rather than discussing particular bills or proposals, I will focus my testimony on analysis of the current system and the general types of change which are needed, rather than the details of our position.

In recent years, WBGH's members have devoted considerable attention to the malpractice liability system. We have concluded that the current system (1) does not effectively deter bad medical care, (2) reduces access to needed services while increasing utilization of costly, inappropriate care that can actually threaten patients' health, and (3) resolves claims in an inefficient and inequitable manner. As a result, the malpractice liability system is in need of fundamental reform.

The time for reform is now. Although the cost of malpractice insurance and the number of claims paid have stabilized or declined in recent years, there is little reason for satisfaction with the status quo. Claims and premiums remain far higher than they were a decade ago. The system continues to perform very poorly in the three ways specified above. Finally, there are early indications that we may be entering a new cycle of increased malpractice costs. Between 1989 and 1990, malpractice insurers' loss ratio increased by about 10%, and during 1990 the nation's largest malpractice liability insurer detected an increase in the number of claims filed. Until we make structural changes in the malpractice liability system, it will continue to hold patients, providers and payers at unjustified risk.

Before proceeding to WBGH's analysis of the current system and agenda for reform, I note that the system's few defenders often claim that their resistance to change is based on malpractice victims' "rights." This argument grossly distorts the issue. First, the system does a poor job of vindicating the rights at issue. We can and must do better for all parties concerned. Second, many state supreme courts and the U.S. Supreme Court have upheld a wide range of malpractice reforms, despite intense legal challenges. Third, Congress has modified how a number of different types of civil claims are addressed, when there have been compelling public policy reasons to do so. This has been the case, for example, in areas such as workers' compensation, labor law and employment law. In our view, the poor results which patients, providers and payers obtain from the current malpractice system creates a strong case for solving the system's problems, rather than standing pat on a false rhetoric of "rights."

II. The Malpractice Liability System's Flaws

A. Failure to Deter Bad Care

A principal purpose of the medical liability system is to deter negligent care. While the incidence of negligent care is difficult to measure, it appears that the current liability system does not effectively reduce medical negligence.

The two major studies of the incidence of medical malpractice cover California hospital discharges in 1974 and New York hospital discharges in 1984. Both found provider negligence in about 1% of cases. While caution must be used when comparing the results of different studies conducted in different times and places these two studies provide the best data available at this time. National data indicate that between 1974 and 1984 the frequency of claims made against physicians rose by about 300%. Malpractice insurance premiums also rose dramatically. If the malpractice system operates as an effective deterrent, we would expect these increases to result in a significant decrease in the number of negligently-treated patients. Of course, the reduction did not materialize.

Clearly, inappropriate, unnecessary and poor quality health care -- whether or not defined as negligent -- is a major problem which permeates our health care system. In fact, the need to emphasize quality improvement has been a central focus of WBGH testimony on comprehensive health system reform for the past several years. However, for a variety of reasons, (e.g., arbitrary results, the filing of many non-meritorious claims, and long lag times between the provision of negligent care and resolution of claims) the current malpractice liability system contributes less than a reformed system would to quality improvement.

B. Reduced Access to Needed Services and Promotion of Defensive Medicine

1. Access

The current malpractice liability system has placed high barriers in front of poor women and women living in rural areas when they seek prenatal care. In a country with a shamefully high infant mortality rate, this result makes little sense -- especially since the rate of negligent obstetrical care is known to be extremely low. Other members of today's panel will speak to this issue in detail, so I will not discuss it further.

Malpractice costs also limit access to care by the burden they place on Community Health Centers, which are sometimes the only source of appropriate care for vulnerable populations such as poor pregnant women, HIV-infected persons and homeless persons. In 1989, Community Health Centers' malpractice premiums equalled 10% of total federal grant funds awarded to help the Centers provide care.

2. Defensive Medicine

The current malpractice system's cost encompasses both direct premium costs (used to pay claims and overhead) and the cost of defensive medicine. Premium costs for physicians and hospitals are about $7 billion per year. Notably, the premium cost per physician (roughly $15,000 per year) is in about ten times as high in the U.S. as in Canada.

The cost of defensive medicine (i.e., services rendered to protect the provider against malpractice liability rather than to benefit the patient) is, of course, more difficult to calculate, but estimates generally suggest it is in the range of $10 to $20 billion per year. In assessing this estimate, it is important to recognize that overutilization can profit providers, in addition to protecting them against litigation. This points to the need to consider malpractice reform along with comprehensive health system reform. However, despite the multiple incentives for the delivery of inappropriate defensive care, there is broad consensus that defensive medicine is a real the phenomenon. At a minimum, eliminating the need for defensive medicine would set the stage for broader efforts to reduce the large amount of inappropriate and unnecessary care now provided to patients.

The use of electronic fetal monitoring during deliveries provides one important example of defensive medicine. According to one recent report, a Utah malpractice insurer found that failure to use fetal monitors was one of the delivery practices implicated in the bulk of successful malpractice claims. It now requires all of the physicians it insures to use fetal monitors in all deliveries. Yet two years ago the Institute of Medicine reported that studies of fetal monitoring "do not support [its] effectiveness in reducing neonatal mortality and morbidity."

Defensive medicine is not only costly -- it also harms patients. Extra procedures carry extra risk. One study has found that Caesarean-section rates increase as malpractice premiums go up. Caesarean-sections produce more maternal deaths than vaginal deliveries, as well as unnecessary medical costs and unnecessary pain and suffering. The Institute of Medicine has noted a correlation between fetal monitor use, which is stimulated by the current malpractice system, and Caesarean-section rates.

c. Inefficiency and Inequity

The malpractice liability system incurs extraordinarily high transaction costs. Studies estimate that only about 30% of premium payments reach claimants as compensation. The remainder is spent on administrative costs, including the cost of defending claims, and plaintiffs' attorney fees. Notably, defense costs have skyrocketed. Between 1980 and 1984 they rose by 400%, a much higher rate than experienced in other types of liability claims.

Much of the system's excessive and wasteful administrative cost is incurred because it does so poorly at deterring the filing of non-meritorious claims, and at winnowing out such claims before they go to trial. About three of every five claims are closed without any payment for damages sustained by the claimant, but not without generating administrative costs. Plaintiffs win between 20% and 40% of the cases which reach the trial stage, as compared to over 60% for other types of liability cases. This record suggests that inappropriate incentives drive the medical liability system, encouraging and keeping alive non-meritorious claims. The system's poor screening of claims does not end with the jury's decision. Medical malpractice awards are more likely than other types of liability awards to be reduced after a verdict.

The system's inequities are as striking as its inefficiencies. The Harvard study of negligence in New York hospitals found that fewer than one out of 16 malpractice victims receive compensation. In fact, most never file claims (though half the claims that were filed were determined to be without merit). We caution that too much can be made of this widely cited finding. The large majority of malpractice victims sustained only minor harm, while others who were harmed more severely incurred only limited financial damages. It is also likely that some injured persons recover most of their losses from collateral sources, such as health and disability insurance. Nonetheless, it is clear that some persons with substantial injuries and damages caused by negligence do not receive compensation.

The system's inequities and arbitrariness are also demonstrated by:

- wide variations in damage awards among similar cases;
- awards that are about three times as large as in comparable automobile injury cases, and;
- 400% variation across states in the frequency with which cases are filed.

III. Agenda for Reform

As previously noted, WBGH will soon issue a detailed malpractice liability reform proposal. In light of this hearing's purpose, I will discuss the issues which reform must address, rather than the details of our forthcoming proposal.

A. Comprehensive Reform

WBGH believes that malpractice reform must be comprehensive in scope. This means that it must appropriately address all potential targets and theories of liability. Reform that is less than comprehensive in scope will shift liability, but will not correct the system's problems. In this connection, we note the need to be cognizant of rapidly evolving theories of employer and insurer liability in managed care settings. Medical equipment and pharmaceutical manufacturers' liability should also be appropriately addressed.

Reform must also be comprehensive in the sense that it includes an integrated, mutually supporting set of changes. Again, piecemeal changes will not fix what is wrong with the system.

B. Federal Action

Fifteen years of state experiments with limited tort reforms have produced some partial successes, but has not produced comprehensive change. Given (1) the stake of the federal government, multi-state employers, multi-state managed care entities and multi-state malpractice insurers in malpractice reform and quality improvement and (2) the relationship of malpractice reform to comprehensive health system reform, the time for federal action has arrived.

C. Alternative Dispute Resolution

The current system should be replaced by an alternative dispute resolution mechanism, principally fault-based, designed to: speed-up claims resolution, bring greater expertise and consistency to fact-finding and decisions, and reduce transaction costs. Studies of arbitration in California and Michigan, as well as the increasing use of arbitration by HMOs, indicate that it is one model which deserves serious consideration. However, at this time we believe it would be useful to explore a number of different models.

A model which meets the above criteria will compensate more injured persons while closing non-meritorious claims more quickly, encourage earlier settlement through greater consistency of decisions, and send a more rapid and clearer definition of the standard of care to providers.

D. Constraints on Awards

1. No Double Recovery

The collateral source rule is a rule of evidence prohibiting introduction of evidence to a jury that a patient has been reimbursed for his or her injury from any source other than the defendant, such as health or disability insurance. This rule has been modified in about half of the states, but the modifications often leave substantial loopholes for double recovery.

Double recovery should be eliminated. The method chosen to eliminate double recovery should be carefully designed to appropriately allocate the remaining recovery between the negligent provider and collateral sources. Studies suggest that eliminating double recovery reduces both the frequency of claims and the size of awards by about 15%.

2. Joint and Several Liability

Under the doctrine of joint and several liability, all defendants held to be negligent are liable for the entire award. The rule can penalize marginally-related defendants with "deep pockets," and disrupt settlement negotiations. It should be reformed.

3. Limit Non-Economic Damages

As suggested above, malpractice awards do not correlate well with the level of injury sustained by a patient. In addition, non-economic damages substantially exceed damages for monetary losses. Because non-economic damages are difficult to accurately ascertain and are a principal reason for arbitrary variation between malpractice awards, they should be capped at a reasonable level. The experience of several states and findings from studies indicate that this step can significantly reduce the size of judgments and malpractice premiums.

We emphasize that only non-economic damages should be capped. Economic losses resulting from malpractice should remain fully recoverable.

4. Periodic Payment of Large Awards

Large awards should be paid on a periodic basis, rather than in a lump sum. This approach can provide for the economic needs of injured patients and their dependents, while avoiding a windfall payout to third parties when the injured party dies. Furthermore, insurers are better able to appropriately finance large awards under a periodic payment system.

5. Statute of Limitation

Lengthy statutes of limitation should be shortened to allow a reasonable period for filing claims, with appropriate special rules which recognize the unique situation of minors. A shorter statute of limitation enhances the likelihood for a fair resolution of claims, improves insurers' ability to rate premiums, and can hasten identification of negligent practices and providers.

E. Attorney Contingency Fees

Attorney contingency fees should be capped, on a sliding scale related to award size. Contingency fees are often defended as giving attorneys an incentive to screen-out non-meritorious cases. The data presented above on the number of non-meritorious claims filed indicates that they have not performed this function well in the medical malpractice setting. (This may be partly explained by the relative inexperience of the plaintiff's bar. The New York study found that one-third of cases were handled by attorneys who had no other malpractice cases during a three-year period.) Nonetheless, to the extend this function is performed by contingency fees, it would be strengthened by a modified fee schedule.

Contingency fees are also defended as a mechanism to improve plaintiffs' access to legal services. This argument can be overstated. One observer cited in a 1987 General Accounting Office report argues that most lawyers will not accept a malpractice case with an anticipated recoverable amount under $50,000. Furthermore, the principal that contingency fees improve access does not necessarily dictate that fees should reach the very high levels found in many cases. Overall, a sliding fee schedule, combined with a lower cost alternative dispute resolution process, should maintain at least the same level of access as current fee

arrangements. Simultaneously, a sliding fee schedule should reduce any abuse of the contingency fee system which now takes place and return a higher portion of most awards to injured plaintiffs in need of compensation.

F. Physician Licensing and Discipline

Many state physician licensing and discipline agencies are not performing effectively. They should be given strong incentives and adequate means to significantly improve their performance.

In connection with physician licensing and discipline, we note that establishment of the National Practitioner Data Bank was an important step forward. However, the Data Bank has experienced implementation problems. Three issues which deserve careful scrutiny in order to improve the Data Bank's effectiveness are:

- How should a "health care entity" be defined, for the purposes of reporting and obtaining data?
- How should small settlements be reported, in order to both facilitate the settlement of claims and establish an accurate record of provider quality?
- How can access to information in the Data Bank be best organized to benefit the public?

G. Practice Guidelines

Clinical practice guideline criteria can be used to improve quality, reduce the incidence of negligence and the need for defensive medicine, and streamline liability determinations. Malpractice reform should assign a central role to practice guidelines in liability determinations. In addition to specifying how guidelines are to be used in claims resolution, reform legislation should specify a process for evaluation and certification of guidelines by the Secretary of Health and Human Services.

IV. Malpractice Reform and Competing Organized Systems of Care

Poor quality, inappropriate and expensive medical care is partly the result or our fragmented medical care delivery system. For example, our fragmented system lacks even a basic quality improvement tool such as a single medical record for patients. Furthermore, the fact that we must rely on one study from one state to assess the incidence of medical negligence in recent years further demonstrates the failure of our fragmented system to address quality. An adequate health care system would routinely generate such information.

To improve quality, health system reform legislation must go beyond redesigning the malpractice liability system and address the underlying flaws in the way health care is delivered. This entails creating strong incentives for the development of competing organized systems of care. In our working definition of this concept, organized systems of care are vertically integrated financing and delivery systems that use panels of providers selected on the basis of quality and cost-management criteria to furnish members with comprehensive services. The organized systems incorporate continuous quality improvement mechanisms and incentives to provide only appropriate and necessary care into their operations and are accountable to purchasers and patients on the basis of cost, quality and outcomes data. Adopting this proactive strategy will produce far greater benefit than consigning quality improvement solely to a redesigned malpractice liability system.

COMMUNICATIONS

STATEMENT OF PUBLIC CITIZEN HEALTH RESEARCH GROUP

PUBLIC CITIZEN HEALTH RESEARCH GROUP REPORT:
STATE MEDICAL BOARD DOCTOR DISCIPLINARY ACTIONS
1989 RANKING OF STATES

We have just analyzed the Federation of State Medical Boards' December 1990 report regarding doctor disciplinary rates for 1989, the most recent year available. According to our analysis, 1989 is the first year in which the overall rate of serious disciplinary actions per 1,000 M.D.s actually declined, from 2.77 serious actions per 1,000 M.D.s in 1988 to 2.64 such actions in 1989. The overall number of serious disciplinary actions (medical license revocations, suspensions, and probations) increased 1.34%, from 1,489 in 1988 to 1,509 in 1989[1]. This slight increase in the total number of serious disciplinary actions comes after a year of no increase (see Table 1, p.2, and Figure 1 on the following page), as the number of serious disciplinary actions taken in 1988 exactly matched the number taken in 1987.[2] In 1989 21 states increased their serious disciplinary action rate, 24 decreased that rate, and 6 states maintained the same rate.

In June, 1990, Public Citizen Health Research Group Published 6,892 Questionable Doctors Disciplined by States or the Federal Government. However, the newly-received 1989 data was not available at that time (the 1988 data became available in July of 1990). In that book we noted that state medical boards had increased the number of serious disciplinary actions they levied against physicians in 1987, the fourth year of increase in a row, but, based on data from many states, predicted no significant increase in this rate between 1987 and 1989.[3] Indeed, there was no increase from 1987 to 1988, and despite a slight increase from 1988 to 1989, Public Citizen believes that the 1989 disciplinary rates still aren't high enough to accurately reflect the frequency of behavior warranting disciplinary action. For example, under current disciplinary standards, a physician who operates drunk, commits a gross act of negligence, or sexually assaults a patient might receive a mere slap on the wrist from many state medical boards, and might never even be brought to the attention of such boards in other states.

We have previously estimated that well over 100,000 Americans are injured or killed in hospitals each year as a result of doctors' negligence. The fact that most states fail to exert the maximum possible effort to discipline these doctors is one of the most serious threats to the health of American patients.

The public would be much better protected if every state would discipline as many doctors as Missouri, the top state in our rankings for 1989. Missouri had a disciplinary rate of 7.02 serious actions per 1,000 physicians, over 14 times more than Connecticut, which took only 0.48 such actions per 1,000 physicians. If all states had a rate of serious disciplinary action equalling Missouri's, 4,005 doctors would have been sanctioned in 1989, over 2.6 times more than the 1,509 actions actually taken in 1989. This would mean that an additional 2,496 American physicians would have been subjected to serious disciplinary measures, significantly increasing the amount of patient protection against incompetent or otherwise poorly-practicing physicians.

OVERALL U.S. TRENDS

For the sixth time in the last seven years, Public Citizen Health Research Group has analyzed the most recent (1989) data which state medical licensing boards give to their national organization, the Federation of State Medical Boards. The three types of serious disciplinary actions that we use as the basis for ranking the states are 1) revocation of license, 2) suspension of license, and 3) probation. A fourth disciplinary category, which includes reprimands, voluntary surrender of license and a variety of other actions, was excluded from our analysis because the Federation does not release details as to what proportion of these actions substantially affect a physician's license and what proportion do not.

As can be seen in Table 1 below, in 1989 state licensing boards took 1,509 serious disciplinary actions against U.S. physicians. While the number of actions taken by such boards doubled from 1984 (745) through 1987 (1489), 1988 was the first year in which the number of actions did not rise from the previous year. From 1984 to 1985, the number of actions taken jumped by 344, an increase of 46%. The periods between 1985 and 1986, and between 1986 and 1987, each saw a 17% increase in the rate of discipline. This upward trend came to a complete stop in 1988. And though 1989 did see a slight but insignificant increase in the number of serious disciplinary actions taken, it is the second year in a row that the number of such actions has remained essentially the same. It is also the first year that the actual nationwide rate has decreased (from 2.77 serious actions for every 1,000 doctors to a rate of 2.64), despite the fact that the actual number of non-federal doctors has increased 6% (from 538,008 to 570,579[4] doctors).

TABLE 1
SERIOUS DISCIPLINARY ACTIONS AGAINST U.S. PHYSICIANS (M.D.s)
1984-1989

YEAR	1984	1985	1986	1987	1988	1989
NUMBER OF ACTIONS	745	1089	1277	1489	1489	1509
CHANGE FROM PREVIOUS YEAR	--	+344	+188	+212	+0	+20
PERCENT	--	+46%	+17%	+17%	+0%	+1.3%

STATE BY STATE RANKING

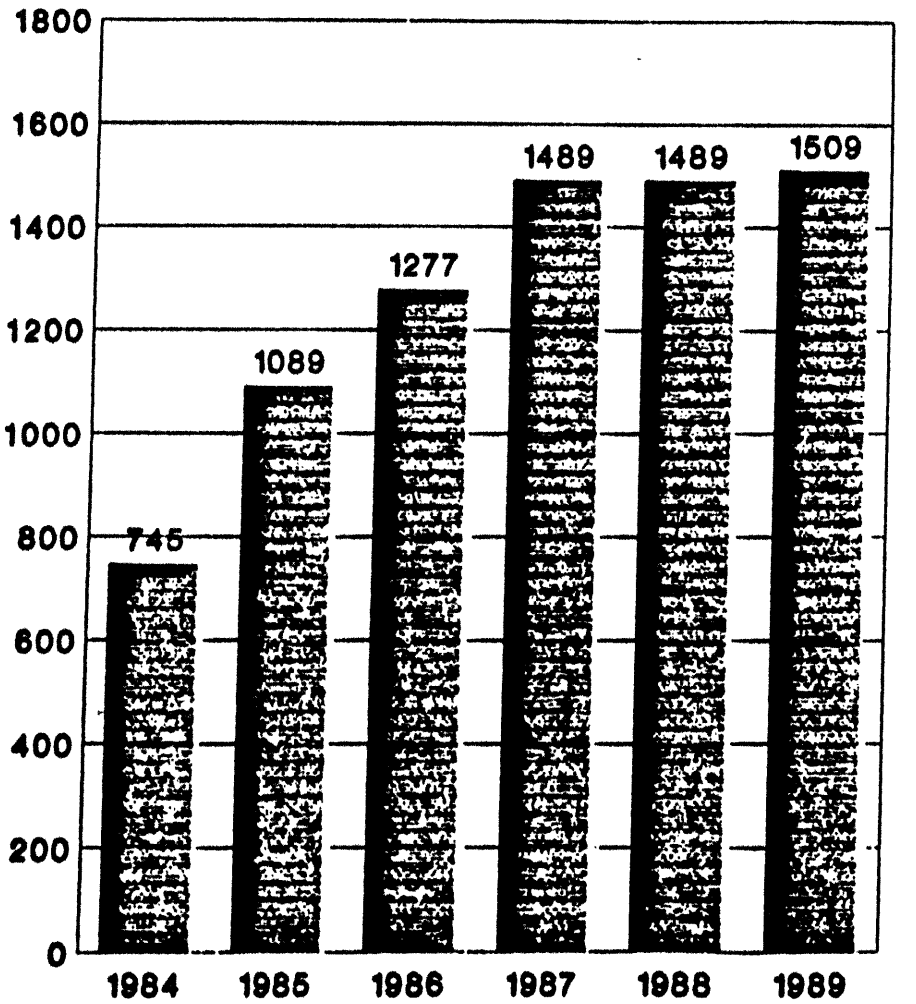
The number and rate per 1,000 M.D.'s of serious disciplinary actions for each state and the District of Columbia in 1989, compared to 1988, can be seen in Table 2 on the following page. These rates are calculated by dividing the number of serious disciplinary actions (reported by each state to the Federation of State Medical Boards) by the number of non-Federal M.D.'s in each state.

TABLE 2

SERIOUS DISCIPLINARY ACTIONS (REVOCATIONS, SUSPENSIONS, AND PROBATIONS) BY STATE MEDICAL LICENSING BOARDS AGAINST MDs IN 1988 AND 1989

RANK 1989	RANK 1988	STATE	# ACTIONS 1989	# ACTIONS 1988	SERIOUS ACTIONS PER 1000 MDs	# OF DOCTORS
1	3	MISSOURI	74	79	7.02	10,536
2	1	GEORGIA	78	90	6.80	11,467
3	6	MISSISSIPPI	24	24	6.63	3,621
4	4	OKLAHOMA	31	38	6.12	5,063
5	8	WEST VIRGINIA	20	19	5.89	3,394
6	2	IOWA	25	37	5.43	4,604
7	15	ALASKA	4	3	5.30	755
8	7	COLORADO	37	42	4.98	7,434
9	20	SOUTH CAROLINA	29	18	4.87	5,951
10	17	INDIANA	45	34	4.84	9,291
11	25	LOUISIANA	39	21	4.49	8,688
12	12	MINNESOTA	44	43	4.33	10,165
13	13	KENTUCKY	28	27	4.27	6,555
14	11	ILLINOIS	112	126	4.25	26,349
15	26	ARKANSAS	15	9	3.91	3,834
16	40	NEBRASKA	11	4	3.79	2,902
17	33	TENNESSEE	35	20	3.50	9,987
18	22	OHIO	77	68	3.39	22,706
19	14	FLORIDA	94	116	3.09	30,377
20	19	NEW MEXICO	9	9	3.01	2,987
21	50	RHODE ISLAND	8	1	2.98	2,685
22	51	MONTANA	4	0	2.83	1,411
23	31	NORTH CAROLINA	36	26	2.78	12,928
24	41	WYOMING	2	1	2.71	738
25	30	OREGON	17	13	2.70	6,296
26	16	NEW JERSEY	51	74	2.54	20,045
27	21	UTAH	8	10	2.43	3,294
28	28	ALABAMA	16	15	2.35	6,812
29	9	HAWAII	6	13	2.23	2,691
30	5	NEVADA	4	12	2.20	1,819
31	35	NEW YORK	130	98	2.17	59,906
32	48	DELAWARE	3	1	2.16	1,392
33	49	ARIZONA	17	4	2.13	7,975
34	44	CALIFORNIA	141	93	1.85	76,272
35	10	SOUTH DAKOTA	2	5	1.84	1,089
36	29	MICHIGAN	33	40	1.81	18,229
37	34	D.C.	7	8	1.80	3,885
38	38	PENNSYLVANIA	51	43	1.69	30,093
39	27	MASSACHUSETTS	33	47	1.57	20,958
40	47	WISCONSIN	15	8	1.53	9,784
41	24	KANSAS	7	12	1.48	4,745
42	39	IDAHO	2	2	1.45	1,384
43	23	VIRGINIA	18	36	1.35	13,299
44	43	VERMONT	2	2	1.26	1,587
45	32	MAINE	3	5	1.21	2,485
46	46	WASHINGTON	11	11	1.01	10,886
47	36	MARYLAND	16	25	0.98	16,268
48	45	TEXAS	29	35	0.94	30,900
49	18	NORTH DAKOTA	1	4	0.84	1,190
50	37	CONNECTICUT	5	15	0.48	10,474
51	42	NEW HAMPSHIRE	0	3	0.00	2,393
TOTALS			1,509	1,489		570,579

SERIOUS DISCIPLINARY ACTIONS* 1984 THROUGH 1989



*Physician license revocations, suspensions, and probations.

Better News

Seven of the top 10 states in 1988 remained in the top 10 in 1989. These include **Georgia, Iowa, Oklahoma, Mississippi, West Virginia, Missouri, and Colorado.**

States demonstrating significant increases in serious disciplinary rates include **South Carolina** (up from 20th to 9th), **Louisiana** (up from 25th to 11th), **Nebraska** (up from 40th to 16th), **Tennessee** (up from 33rd to 17th), **Montana** (up from 51st to 22nd and showing the largest single increase), **Wyoming** (up from 41st to 24th), **Delaware** (up from 48th to 32nd), and **Arizona** (up from 49th to 33rd).

In our last report we noted that California and New York, two of the states that take high numbers of serious disciplinary actions, had both declined in our ranking. This was especially alarming in the case of New York, which took fewer than half the actions in 1988 (98) as it had in 1987 (259). Fortunately, both states increased the number of serious disciplinary actions they took in 1989. However, even though California rose from 93 actions (44th) to 141 (34th) and New York rose from 98 actions (35th) to 130 (31st), both were still well under one third the rate of serious disciplinary actions taken by Missouri.

It should also be noted that **Georgia, Iowa, and Oklahoma** have been in the top 10 states for doctor disciplinary rates for five years in a row, and **West Virginia** has been in the top 10 for four consecutive years. While the number of serious disciplinary actions taken by a state may fluctuate from year to year for a number of reasons, the fact that these states have consistently ranked at or near the top of the list suggests a consistent effort to improve the quality of health care available in these states.

Worse News

At the other end of the scale, 14 of the bottom 20 states for doctor disciplinary rates in 1988 remained there in 1989. Of these 14 states, 4 showed increases in disciplinary rates (**Delaware, Arizona, California, and Wisconsin**), 2 maintained a steady rate (**Pennsylvania, and Washington**), and 8 actually declined (**the District of Columbia, Idaho, New Hampshire, Vermont, Maine, Maryland, Texas, and Connecticut**).

Two other states, in the bottom 20 for the first time, showed enormous declines in their disciplinary rates. **North Dakota** fell from 18th to 49th, a drop of 31 places. And **South Dakota** fell 25 places, plummeting out of the top 10 from 10th to 35th. Unfortunately, two other states dropped out of the top 10 as well: **Hawaii** fell 20 places, from 9th to 29th; and **Nevada** fell 25 places, from 5th to 30th.

Other declines were seen for **Massachusetts** (which fell from 27th to 39th) and **Kansas** (which fell from 24th to 41st). **New Hampshire** retains the distinction of having the worst disciplinary rate for 1989, with no serious disciplinary actions taken in that year.

IMPLICATIONS OF LOW RATES OF DOCTOR DISCIPLINE

The implications for all states, especially those with low doctor disciplinary rates, are quite serious. Public Citizen estimates that at least 100,000 Americans are injured or killed each year by doctor negligence, based on the results of three studies.

In the first, Harvard researchers recently found that 1 percent of a representative sample of patients treated in New York state hospitals in 1984 were injured, and one quarter of those died, because of medical negligence.[5] Nationwide, that translates into 234,000 injuries and 80,000 deaths in 1988 from negligence in American hospitals.

A similar study conducted in California in 1974 found that 0.8 percent of hospital patients had either been injured by negligence in the hospital or had been hospitalized because of negligent care.[6] Extrapolation of those findings yields an estimate of 249,000 injuries and deaths from negligence in 1988.

In 1976 the HEW Malpractice Commission estimated that one-half of one percent of all patients entering hospitals are injured there due to negligence.[7] That estimate would indicate 156,000 such injuries and deaths resulted from doctor negligence in 1988.

Since there is no evidence that doctors in any one state are generally more or less competent than in another, differences in the rate of doctor discipline reflect differences in how serious states are about disciplining doctors. The disparity between states with higher rates of doctor discipline and states with only a fraction of those rates is cause for alarm by the residents of the low-discipline states. People in these states are much more likely than people in high-discipline states to be injured or killed by doctors still on the loose because they haven't been "caught". What would be unacceptable medical practice in one state may go unnoticed by the state licensing board in another state.

Even though the 1989 total of 1,509 serious doctor disciplinary actions demonstrates a slight increase over the 1987/1988 total, it falls very short of catching most of the incompetent doctors in this country. Most states base more disciplinary actions on doctors' drug and alcohol problems (9.2%) than on medical negligence or incompetence (8.9%).[8] Boards say proving incompetence is difficult, and investigations of substandard care soak up resources like a sponge. Instead, they use prescription violations and fraud convictions, offenses that are easier to document because they leave a paper trail, as potential indicators of more serious violations. While this may catch those doctors whose ability to practice medicine has been impaired by chemical dependency, it does not adequately address the issues of quality of care that are not related to such a dependency.

A further indication that the rate of doctor discipline by most state medical boards is too low comes from a 1989 Tufts University study.[9] Those researchers found that physician-owned insurance companies terminated coverage of 6.6 out of every 1,000 policyholders in 1985 because of negligence-prone behavior. In addition, they restricted the practice or imposed other medical sanctions on an additional 7 of every 1,000 policyholders, whose performance was viewed as substandard. Thus, if the combined rates of malpractice insurance termination and other sanctions by physician-owned insurance companies (13.6 per 1,000 physicians) were applied to all physicians in the U.S., this rate would be more than 5 times higher than the actual 1989 average rate of serious disciplinary actions by state licensing boards and would affect a total of 7,760 physicians.

DOCTOR DISCIPLINE AND MEDICAL MALPRACTICE

Until the rate of doctor discipline in this country significantly increases, there is no realistic possibility of a major decrease in the amount of medical malpractice or medical malpractice litigation. At the heart of the so-called medical malpractice litigation crisis, other than the manipulative efforts of the insurance industry, is actual malpractice, that is, patients being injured or killed by negligent physician behavior.

WHY WAS MISSOURI NUMBER ONE IN DOCTOR DISCIPLINARY ACTIONS IN 1989?

The Missouri State Board of Registration for the Healing Arts is one of the best medical disciplinary boards in the country. The board has proven its excellence by achieving the highest disciplinary rate on our 1989 list, and by steadily rising in our rankings from 11th in 1987 to 3rd in 1988 to its present position.

As we noted in our report 6,892 Questionable Doctors Disciplined by States or the Federal Government, Missouri has had a strong medical disciplinary board for the past several years, and amendments to the state's Medical Practice Act, passed in 1987, have only made it stronger. It is one of the few boards that does not wait for formal complaints against doctors before initiating investigations; it seeks out errant physicians on its own. (Georgia, Mississippi, Oregon, Utah, Virginia, and West Virginia also proactively seek out poorly practicing physicians.)

Interestingly, it was only in 1987 that any of the Missouri board's actions became public. However, the board *may* still enter into confidential disciplinary consent orders with any physician it chooses, which may not always be in the best interests of consumers. Furthermore, the state is also prohibited from publishing the names of physicians who voluntarily enter substance abuse treatment programs and have been placed on probation by the board. Missouri's rate of confidential disciplinary actions may in fact have boosted its 1989 serious disciplinary action rate even higher.

RECOMMENDATIONS FOR THE FEDERAL GOVERNMENT

1. **Create grants and standards.** Congress should create a small program of grants-in-aid to state medical boards. The grants should be tied to the boards' agreements to meet certain performance standards, which should be developed by the Public Health Service, as the Department of Health and Human Services Office of Inspector General recommended in 1990.[10]

In developing these standards the Public Health Service should work with the Federation of State Medical Boards' Assessment Task Force. In September, 1990 the FSMB received a federal contract for $200,000 to undertake the development of a self-assessment instrument for state medical boards. The goal of the task force is to produce a sound and objective means by which the boards can assess their performance over time and in comparison with other boards.

The standards should include (but not be limited to) the following: processing complaints within a certain limited period of time; maintaining a certain level of staffing and having staff meet certain qualifications; disseminating disciplinary information to the public; and other standards.

2. **The Medicare Peer Review Organizations**, which have been practically moribund in disciplining physicians for substandard

care, should become more aggressive. The PROs should hire investigators and advisers trained in law enforcement, so that fewer of their sanctions will be overturned.

As a 1990 Institute of Medicine report noted, the PROs are not evaluated on their ability to detect and correct poor quality care.[11] The Department of Health and Human Services should change its evaluation procedures to place more emphasis on quality.

3. **Open the National Practitioner Data Bank.** In 1986 Congress passed the Health Care Quality Improvement Act. This act mandated the establishment of a data bank containing information on adverse professional review actions taken against doctors, and on doctors who had been sued for malpractice and on whose behalf settlement or adjudicated payments had been made. Unfortunately, the law establishing the data bank also required that it be closed to the general public. Congress should pass legislation opening the data bank to the public.

4. **The Drug Enforcement Administration** should release a monthly list of all practitioners whose controlled substance prescription licenses have been revoked, restricted, or denied. The list should be widely distributed to pharmacies, state pharmacy and medical boards, and the general public.

Far too many doctors continue to prescribe controlled substances after their DEA licenses have expired or have been revoked. The DEA should consider requiring pharmacies to subscribe to an on-line service with which they could check the validity of these DEA license numbers.

5. **Require doctor recertification.** Congress should consider legislation proposed by Rep. Pete Stark, D-Calif., to require physicians who accept Medicare patients to be periodically recertified for competency.

RECOMMENDATIONS FOR STATES

1. **Strengthen the statutes.** States that have not already done so should adopt a version of the Model Medical Practice Act developed by the Federation of State Medical Boards[12], or, preferably, stronger laws.

2. **Restructure the Boards.** States should sever any remaining formal links between state licensing boards and state medical societies. Members of medical boards (and separate disciplinary boards, where present) should be appointed by the governor, and the governor's choice of appointees should not be limited to a medical society's nominees.

At least 30 percent of the members of each state medical board and disciplinary board should be public members who have no ties to health care providers.

The governor should appoint members to the Medical Board whose top priority is protecting the public's health, not providing assistance to physicians.

3. **Inform the public.** Each state's Open Records Law and its Medical Practice Act should state that all formal disciplinary actions against licensed professionals are fully public records.

Each legislature should require widespread dissemination of final disciplinary orders. Lists of those disciplined and full disciplinary orders should be promptly available to all requesting them by mail.

Notices of disciplinary actions should be sent to the local news media and to all hospitals, HMOs, and other health care providers in the state, as well as to other state agencies, the federal Department of Health and Human Services, and the federal Drug Enforcement Administration. Federal law already requires that such information be reported to the National Practitioner Data Bank, which began operating on September 1, 1990.

4. **Strengthen board authority.** Every medical board should have the authority to impose emergency suspensions pending formal hearing in cases where there is a potential danger to the public health. Boards should aggressively use this authority when they learn of a potentially dangerous doctor.

Medical boards should have the authority to accept the findings of other state boards and of the federal Department of Health and Human Services and the Drug Enforcement Administration. If a physician has been disciplined by another state, the second state's medical board should be required to impose sanctions at least as stringent as those imposed by the first state.

Each state should require physicians who have been licensed in other states and who seek licensure in a new state to submit affidavits that they are not under investigation elsewhere before being granted a new license. Physicians who are under investigation should not be permitted to practice until the board has heard the details of their case and can evaluate their competency.

Each legislature should provide its state medical licensing board with authority to examine physicians for physical, mental and professional competence and to test them for alcohol and drug use upon reason to believe that a problem exists in one of these areas.

5. **Encourage complaints.** Each legislature should provide for the protection of confidentiality and immunity to those who report violations of the Medical Practice Act to the Board. Such protections should also be extended to board members, their staff and consultants.

Each legislature should require all licensed health care practitioners to report Medical Practice Act violations by other practitioners to the medical board, with large civil penalties for failure to do so. Boards should aggressively use their authority to enforce the requirement that all health care providers report such violations. Each legislature should also require hospitals to report all revocations, restrictions, or voluntary surrenders of privileges.

Courts should be required to report all indictments and convictions of physicians to the medical disciplinary board. In addition, each legislature should require liability insurers to report all claims, payments, and policy cancellations to state medical disciplinary boards. It should request reports from other state agencies, Medicare, the DEA and other federal agencies. It should also require impaired physicians' programs to report the names of doctors who fail to successfully complete the program.

Medical boards should conduct random audits of institutions to check compliance with these reporting requirements, and should fine those who fail to comply. After a doctor is disciplined, a board should fine any other practitioners who knew of that doctor's offense, but failed to report it.

6. **Keep the courts in check.** Each legislature should pass laws that make clear their intent that the judgements of the medical board be given extreme deference, and that, barring extraordinary circumstances, disciplinary actions should take immediate effect pending appeal.

Each legislature should adopt the 'Preponderance of the Evidence' standard of proof in medical disciplinary cases, replacing the tougher-to-meet 'Clear and Convincing Evidence' standard now in effect in most states. According to the August, 1990 report on state medical boards issued by the Office of the Inspector General, "The 'clear and convincing evidence' standard of proof is more rigorous than the 'preponderance of evidence' standard that is typically required to justify tort damages for negligence in civil cases. The more rigorous standard provides greater protection for physicians, but adds complexity to the investigative process and appears to make it less likely that a board will persevere on a case through a full evidentiary hearing."[13]

Furthermore, the Project Work Panel of the Federation of State Medical Boards, in its August 1989 report Elements of a Modern State Medical Board: A Proposal, recommended that each state medical board "use preponderance of evidence as the standard of proof" and that they each have the power "to issue final decisions when acting as trier of fact in the performance of [their] adjudicatory duties".[14]

7. **Beef up funding and staffing.** Each legislature should permit the medical board to spend all the revenue from medical licensing fees, rather than being forced to give part to the state Treasury. The medical boards should raise their fees to $500 a year.

All boards could benefit from hiring new investigators and legal staff. Boards should ensure adequate staff to process and investigate all complaints within 30 days, to review all malpractice claims filed with the board, to monitor and regularly visit doctors who have been disciplined to ensure their compliance with the sanctions imposed, and to ensure compliance with reporting requirements.

They should hire investigators to seek out errant doctors, through review of pharmacy records, consultation with medical examiners, and targeted office audits of those doctors practicing alone and suspected of poor care. "Physicians who have problems," comments Department of Health and Human Services Inspector General Richard Kusserow, "have retreated to areas where they cannot be observed."

8. **Require risk management.** States should adopt a law, similar to one in Massachusetts, that requires all hospitals and other health care providers to have a meaningful, functioning risk management program designed to prevent injury to patients. Massachusetts also requires all adverse incidents occurring in hospitals or in doctors' offices to be reported to the medical board.

9. **Require periodic recertification** of doctors based on a written exam and audit of their patients' medical care records.

RECOMMENDATIONS TO CONSUMERS

1. **Complain.** File your complaints about poor medical care or medical misconduct with your state medical board and with the federal Department of Health and Human Services. If the offense occurred in a hospital, also file a complaint with the hospital peer review committee.

Your complaints are needed to protect others!

2. **Organize.** Form citizens' action or victims' rights groups to improve medical quality assurance in your area. The American Association of Retired Persons publishes a guide that can help you mobilize a group for reform.[15] Try to get a representative of your group appointed to the state medical board or the Medicare Peer Review Organization for your state.

3. Write to your Congressperson and voice your support for the opening of the National Practitioner Data Bank to the general public.

Notes

1. Winn, James R. "Official 1989 Federation Summary of Reported Board Actions," FSMB News Release December, 1990.

2. Public Citizen Health Research Group. State Medical Licensing Board Doctor Disciplinary Actions in 1988 July, 1990, p. 1.

3. Public Citizen Health Research Group. 6,892 Questionable Doctors Disciplined by States or the Federal Government June, 1990, p. xiv.

4. Physician Characteristics and Distribution in the U.S. American Medical Association, 1990.

5. Harvard Medical Practice Study Group. "Patients, Doctors and Lawyers: Medical Injury, Malpractice, Litigation and Patient Compensation in New York," 1990.

6. Mills, D. H. ed. California Medical Association and California Hospital Association Report on the Medical Insurance Feasibility Study Sutter Publications, 1977.

7. Journal of Legal Medicine February, 1976.

8. Public Citizen Health Research Group. 6,892 Questionable Doctors, op. cit. p. xxii, Table 3.

9. Schwartz, William B. and Mendelson, Daniel N. "The Role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence," Journal of the American Medical Association 1989, vol. 260, no. 10, pp. 1342-1346.

10. "State Medical Boards and Medical Discipline," Office of Evaluation and Inspections, Office of the Inspector General, U.S. Department of Health and Human Services, August, 1990, pp. 21-23.

11. Lohr, Kathleen N., and Schroeder, Steven A., Institute of Medicine. "A Strategy for Quality Assurance in Medicare," New England Journal of Medicine vol. 322, no. 10, March 8, 1990, pp. 707-712.

12. Federation of State Medical Boards. Elements of a Modern State Medical Board: A Proposal August, 1989.

13. Office of the Inspector General, op.cit., p. 9

14. Federation of State Medical Boards, op.cit., p. 14.

15. American Association of Retired Persons. "Effective Physician Oversight: Prescription for Medical Licensing Board Reform", 1987.

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