

## Testimony of Philip K. Howard

Before the Senate Committee on Health, Education, Labor and Pensions  
Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients  
June 22, 2006

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

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

Special health courts are intended not simply to provide a better dispute resolution mechanism, but to provide a foundation from which deliberate choices can be made to restore order to American healthcare. The current ad hoc system, in which cases are decided jury by jury, without guidelines or precedent, has contributed to a debilitating distrust that makes reforming healthcare almost impossible. Special health courts, by contrast, can offer guidance on standards of care and the predictability needed for trust. It is almost impossible to contain costs, for example, until there is a system of justice that is trusted to reliably uphold the costs contained.

Key features of special health courts would include administrative judges dedicated to malpractice disputes, advised by neutral experts and providing written opinions;

liberalized standards of recovery; an expedited process with incentives for providers to make “early offers”; scheduled noneconomic damages, depending on the injury; and a coordinated patient safety department to collect and disseminate important information. We believe special health courts could serve three goals: first, to eliminate the distrust of justice that impedes quality and contributes to skyrocketing costs; second, to provide affirmative incentives to improve the quality of care; and third, to provide a reliable, efficient and quick compensation system for patients injured by faulty care.

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

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

Many of the organizations supporting special health courts have not been supporters of “tort reform.” But they support this effort to restore reliability because the goal is not just to provide relief to physicians but to create a system that is reliable for doctors and patients alike. The proposal enjoys broad editorial support in publications including *USA Today*, *The Economist*, *Newark Star-Ledger*, the *Detroit News*, and the *St. Louis Post-Dispatch*, among

others. The public also seems to like the idea: a Harris Interactive survey found that two out of three Americans support the creation of special health courts.<sup>1</sup>

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

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

- While the system provides miracle cures admired across the world, it tolerates too many avoidable errors – causing upwards of 100,000 unnecessary deaths annually, according to the Institute of Medicine.<sup>2</sup>
- Accountability is inconsistent: inept doctors often keep their licenses while good doctors find themselves liable on baseless claims; one out of four baseless claims

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

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

result in payment, according a recent study by Professor Studdert and others in *The New England Journal of Medicine*.<sup>3</sup>

- Skyrocketing costs — now approaching twice that of other developed countries, with no better outcomes — make health care insurance unaffordable for one out of 7 Americans.<sup>4</sup>

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

The Effects of Law on Healthcare. The debate over liability has focused on the rise in malpractice insurance premiums, and whether noneconomic damages need to be “capped.” Doctors in certain specialties, such as obstetrics, desperately need relief. But the total cost of the malpractice system, about \$28 billion, while huge, represents only about one and a half percent of total healthcare spending.<sup>5</sup> If doctors’ premiums were the only problem, surely we could come up with a solution. The debate has generated more heat than light, with each side arguing about the fairness either to doctors or to injured patients. A strong case can be made, as will be discussed shortly, that the current system is fair to neither.

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<sup>3</sup> Studdert, David M. et al., “Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,” *New England Journal of Medicine*, vol. 354; May 2006, p. 2029.

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

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

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

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

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

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

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

<sup>7</sup> Sage, William, “Medical Liability and Patient Safety,” *Health Affairs*, Vol. 22; 2003, p. 26-36, available at: <http://content.healthaffairs.org/cgi/content/full/22/4/26?ijkey=f437af2d1c6ff94a693f160a23e55bf82b3de843>

- The effects of law on healthcare costs. “Defensive medicine” — the practice of ordering tests and doing other unnecessary activities--is nearly universal. Although the costs of defensive medicine are almost impossible to quantify-- estimates range from a few tens of billions to over \$100 billion-- no person who has encountered the healthcare system has not experienced it.<sup>8</sup> I was not allowed to have minor surgery recently until I’d gone through a complete pre-operative examination, complete with chest X-rays and other tests, at a cost to my insurer of \$1500. This was basically the same exam I had undergone a few months before at my annual physical, but the hospital would not accept those results, or indeed, even allow me to waive any claim. This was \$1500 not available for some person who needed care. Nor is the cost just

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

monetary--unnecessary tests reduce immunity and increase the chance of complication.

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

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

- The effects of law on accountability. All people, including doctors, make mistakes, and they should fairly compensate those injured. The most important accountability, however, is licensure--bad doctors shouldn't be allowed to continue practicing. Although it is often stated that 5 percent of the doctors result in a majority of all claims, this number is misleading because high-risk specialties attract a

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<sup>9</sup> US Department Of Labor: Bureau of Labor Statistics, May 2005 National Occupational Employment and Wage Estimates for the United States, available at: [http://www.bls.gov/oes/current/oes\\_nat.htm](http://www.bls.gov/oes/current/oes_nat.htm).

disproportionately high number of claims.<sup>10</sup> The current system makes it hard to hold bad doctors accountable-- they hire a lawyer, threaten to drag the hospital or licensing board through years of litigation. A typical result is a settlement that allows the doctor to continue practicing.

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

Distrust of justice is driven not just by the chance of error, but by the years-long process--an average of five years to get to *settlement*, in Professor Studdert's study. Even where the doctor ultimately prevails, a lawsuit is a horrible life-changing experience. For years the

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

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

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

doctor goes to bed each night trying to figure out how to justify some choice made. I commend to the Committee the recent essay in *The New Yorker*, "The Malpractice Mess," by Dr Atul Gawande.

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

Overall, while justice today eventually gets to the right result about three quarters of the time, this would not be considered a tolerable risk in other comparable professional activities (certainly not in healthcare). The combination of the risk of error, the harrowing process and growing costs has resulted in nearly universal distrust of American justice. This

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<sup>13</sup> Sage, William, online discussion at PointofLaw.com, "Why Flatter The Trial Lawyers?," Dec. 6, 2005, available at: [http://www.pointoflaw.com/feature/condition\\_critical1205.php](http://www.pointoflaw.com/feature/condition_critical1205.php)

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

<sup>15</sup> In a recent study, Harvard School of Public Health researchers found that the cost of litigating claims in the study sample consumed 54 percent of plaintiffs' awards. Studdert, David M. et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine*, vol. 354; May 2006, p. 2031. Tillinghurst-Towers Perrin has estimated that only 22 cents of a dollar moving through the U.S. tort system compensates a plaintiff for economic loss. 54% of that dollar never even reaches the victim (21% goes to administrative costs; 19% goes to the plaintiff's attorney fees; and 14% goes to defense costs.) Tillinghurst-Towers Perrin, "U.S. Tort Costs, 2003 Update," December 2003, p. 17.

distrust, in turn, acts as a kind of acid corroding American healthcare. Quality, cost, professionalism, patient empathy, accountability and effective compensation for injured patients are all adversely affected by the defensive culture.

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

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

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

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

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

(3) Noneconomic damages paid according to a schedule depending on the injury.

This achieves horizontal equity among injuries of the same kind, and also eliminates the incentive to keep litigating in the hopes (or threats) of a windfall award.

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

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

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

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

The constitutional authority to create an administrative compensation system in place of a traditional jury trial is clear where it is part of a regulatory plan to improve healthcare. Congress has broad powers to authorize pilots for specialized health tribunals under the Spending Clause, see *South Dakota v. Dole*, 483 U.S. 203 (1987); and under the Commerce Clause because medical injury litigation is economic activity that is in and affects interstate

commerce. See *Gonzales v. Raich*, 125 S.Ct. 2195 (2005); *United States v. Lopez*, 514 U.S. 549 (1995). Contrary provisions of state law, if any, would be pre-empted under the Supremacy Clause. See *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238 (1984); *Pennsylvania v. Nelson*, 350 U.S. 497 (1956). Moreover, similar federal administrative compensation systems have been upheld against constitutional challenge. *Colaio v. Feinberg*, 262 F. Supp. 2d 273 (S.D.N.Y. 2003), *aff'd* *Schneider v. Feinberg*, 345 F.3d 135 (2d Cir. 2003).

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

Thank you.