

AMERICA'S FAILING MALPRACTICE SYSTEM
WHY HEALTH COURTS MAKE SENSE

▪ **America's medical malpractice system fails patients and health care providers.**

Few medical error victims receive compensation in the current system.¹ Much of the cost (as much as 60%) is consumed by legal fees and administrative costs.²

The high cost of malpractice insurance is a major issue in many states, with doctors and hospitals struggling to maintain patient access to services.³

The current legal system hinders patient safety by discouraging health care providers from reporting information about errors and near misses in treatment.⁴

Skyrocketing health care costs are the result, in part, of a culture of defensiveness.⁵ It is impossible to make the choices to contain costs until there is a legal system that will reliably uphold those choices.

▪ **A new approach to medical justice is needed – one that fairly compensates injured patients, relieves strain on health care providers, and promotes quality care. Health courts are the right solution.**⁶

Health court judges will have health care expertise and will issue written rulings, leading to more reliable verdicts. Verdicts will be based on better information, since judges will rely on neutral medical experts – not competing experts for hire.

More injured patients will be eligible for compensation. The claims process will involve less time and less hassle than a court trial does.

Health courts can help to reduce the need to find fault in the aftermath of a medical mistake, reducing the combativeness of the system.

Non-economic awards based on schedules will be more consistent and less arbitrary. Greater consistency of verdicts in like cases will encourage parties to resolve conflicts quickly, a win-win for both parties.

▪ **A broad coalition supports creating health court pilot projects.**

The health court proposal has been developed by a joint venture of Common Good (www.cgood.org) and the Harvard School of Public Health, with the support of the Robert Wood Johnson Foundation.⁷

The Progressive Policy Institute has endorsed health courts. AARP has called for pilot projects. A broad array of leading citizens have endorsed health courts, including former senators Bill Bradley and Alan Simpson, former justice officials Griffin Bell, Eric Holder and Larry Thompson, and dozens of university presidents and corporate leaders.⁸

JCAHO, patient safety authorities, and many medical organizations support health court pilots.⁹

The *New York Times* has called for demonstration projects to explore new approaches to resolving malpractice disputes. *USA Today* and the *Economist* have endorsed health courts, and favorable coverage has been received in many other publications.¹⁰

¹ Numerous academic studies have confirmed the fact that few patients are compensated by the existing system. For example, the landmark Harvard Medical Practice Study Part III found that only 2 percent of patients in the sample who had suffered injury due to negligence actually filed a claim. The authors concluded that “[m]edical-malpractice litigation infrequently compensates patients injured by medical negligence and rarely identifies, and holds providers accountable for, substandard care.” Localio, A.R., Lawthers, A.G., Brennan, T.A., et al, “Relation between malpractice claims and adverse events due to negligence. Results of the Harvard Medical Practice Study III,” *New England Journal of Medicine*, vol. 325, 1991, p. 245-251. These findings have been confirmed by later studies. See e.g., Studdert, D.M., Brennan, T.A., and Thomas, E.J., “What We Have Learned Since the Harvard Medical Practice Study?” in M.M. Rosenthal and K.M. Sutcliffe, editors, *Medical Error: What Do We Know? What Do We Do?* (San Francisco: Jossey-Bass, 2002), p.7-8, 17.

² See Danzon P.M. “Liability for Medical Malpractice,” in *Handbook of Health Economics*, Volume 1B (AJ Culyer & JP Newhouse, eds.). New York: Elsevier, 2000. 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. Moreover, nearly 80 percent of these administrative expenses went to the resolution of claims that involved harmful errors. Studdert, D.M., Mello, M.M., Gawande, A.A., et al, “Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,” *New England Journal of Medicine*, vol. 354; 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.

³ The American Medical Association currently lists 21 states as in crisis, where the legal system is forcing physicians to retire early, relocate or give up performing high-risk medical procedures. See <http://www.ama-assn.org/ama/noindex/category/11871.html>. Surveys by the Medical Liability Project in Pennsylvania concluded that “the malpractice situation [in the state] is having demonstrable effects on the supply of specialist physicians in affected areas and their scope of practice, which likely impinges upon patients’ access to care. Forty-two percent of the specialists surveyed have reduced or eliminated high-risk aspects of their practice and 50% said they were likely to do so over the next 2 years. Strong majorities of specialists reported increases over the last 3 years in patients’ driving distances (58%) and waiting times (83%) for specialist care or surgery, waiting times for emergency care (82%), and the number of patients forced to switch physicians (89%). Mello, Michelle M., Studdert, David M., DesRoches, Catherine M. et al, “Effects of a Malpractice Crisis on Specialist Supply and Patient Access to Care,” June 2005, available at: <http://medliabilitypa.org/research/files/mello0605.pdf>

⁴ There is widespread agreement among patient safety and health policy experts that the current medical liability system serves as an impediment to improved health care quality. In the landmark Institute of Medicine report *To Err is Human*, for example, the authors noted that “[p]atient safety is also hindered through the liability system and the threat of malpractice, which discourages the disclosure of errors. The discoverability of data under legal proceedings encourages silence about errors committed or observed. Most errors and safety issues go undetected and unreported, both externally and within health care organizations.” Kohn, L.T., Corrigan, J.M. and Donaldson, M.S. Editors; Committee on Quality of Health Care in America, Institute of Medicine, *To Err Is Human*, Academy Press, 2000, p. 43

⁵ 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.

⁶ In a health court system, judges would make rulings about the standard of care, assisted by neutral experts providing unbiased testimony and relying on evidence-based clinical practice guidelines. Rulings by health court judges would begin to establish new standards of practice to cover medical circumstances where common standards have not previously been agreed upon. The health court system would provide an essential benefit where our current system of medical justice fails, by providing consistent, rational rulings that send clear signals to health care providers about what constitutes good medical practice. It would also help eliminate the uncertainty that encourages doctors to practice defensive medicine and contributes to medical errors. See Udell N. and Kendall, D.B., *Health Courts: Fair and Reliable Justice for Injured Patients*, Progressive Policy Institute Policy Report, February 2005, available at: http://www.ppionline.org/documents/healthcourts_0217.pdf. See also Barringer, P.J., "Health Courts: A Better Approach to Malpractice Reform," *BNA Health Law Reporter*, June 23, 2005, available at: <http://cgood.org/healthcare-reading-cgpubs-opeds-43.html>.

⁷ With support from the Robert Wood Johnson Foundation (RWJF), Common Good is working with the Harvard School of Public Health to design a model for a new injury compensation system featuring administrative health courts with trained adjudicators, neutral experts, scheduled damages, and linkages to patient safety structures. For more information, visit: <http://www.hsph.harvard.edu/press/releases/press001102005A.html.html>. Common Good (www.cgood.org) is a bi-partisan legal reform coalition dedicated to restoring common sense to American law. Its board is composed of leaders in education, healthcare, law, business and public policy. The Chair of Common Good is Philip K. Howard, a lawyer and author of *The Death of Common Sense* and *The Collapse of the Common Good*.

⁸ The Progressive Policy Institute has called for health court pilot projects. See *Fixing America's Health Care System*, by David B. Kendall, Progressive Policy Institute Policy Report, September 2005, available at: http://www.ppionline.org/documents/Fixing_Health_Care_092205.pdf. See also *Health Courts: Fair and Reliable Justice for Injured Patients*, by Nancy Udell and David B. Kendall, Progressive Policy Institute Policy Report, February 2005, available at: http://www.ppionline.org/documents/healthcourts_0217.pdf. A number of prominent leaders in law, business, and medicine have endorsed the health court concept. See *An Urgent Call for Special Health Courts*, available at <http://cgood.org/brochure-hcare.html>.

⁹ See "Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury," Joint Commission on Accreditation of Healthcare Organizations, 2005, pp. 31-33, available at: http://www.jointcommission.org/NR/rdonlyres/167DD821-A395-48FD-87F9-6AB12BCACB0F0/Medical_Liability.pdf. See e.g. Statements by Jackson Williams, Senior Policy Advisor to American Association of Retired Persons, at October 31, 2005 forum entitled "Administrative Approaches to Compensating for Medical Injuries: National and International Perspectives," available at p. 47, http://cgood.org/assets/attachments/Transcript_-_October_31st_Event.pdf. The Institute of Medicine has called for pilot projects to assess the feasibility of administrative compensation mechanisms to resolving medical injury disputes. See *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*, Institute of Medicine, 2002, at pp. 81-88, available at: <http://fermat.nap.edu/books/0309087074/html/81.html>. Medical organizations endorsing the health court concept or supporting pilot projects include the American College of Obstetricians and Gynecologists, the American College of Family Physicians, the American College of Emergency Physicians, and state medical societies in Delaware, Maryland, Michigan, Mississippi, New Hampshire, New Jersey, New York, Rhode Island, and Virginia.

¹⁰ See "Malpractice Mythology," *New York Times*, January 9, 2005. ["Experts have suggested a number of approaches, including special health courts with judges trained to deal with malpractice issues, required mediation, mandatory reporting of errors by doctors and prompt offers of compensation. But there is a lot of uncertainty about what would work best ... Congress should push for a wide range of demonstration projects aimed at solving the malpractice problem by actually cutting down on malpractice."] See also "Health Courts Offer Cure," *USA Today*, July 4, 2005, available at: http://www.usatoday.com/news/opinion/editorials/2005-07-04-our-view_x.htm. *The Economist* has called health courts a "sensible idea." "Scalpel, Scissors, Lawyer," *The Economist*, December 14, 2005. See <http://cgood.org/healthcare-newscommentary-watch-833.html>. For more media coverage, visit: <http://cgood.org/healthcare-newscommentary.html>.