

**COMMON GOOD
AND
HARVARD SCHOOL OF PUBLIC HEALTH**

**ADMINISTRATIVE APPROACHES
TO COMPENSATING FOR MEDICAL INJURIES:
NATIONAL AND INTERNATIONAL PERSPECTIVES**

**MONDAY, OCTOBER 31, 2005
1:00 – 5:00 P.M.**

PRESENTERS:

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*Transcript by:
Federal News Service
Washington, D.C.*

PAUL BARRINGER : Good afternoon. I'm the general counsel of Common Good. I'm really happy to see everyone here, and I want to thank all of you for being here with us this afternoon. We are really pleased to have the opportunity to convene this event and to present what I'm confident are going to be a number of really interesting and thought-provoking presentations, with insights about administrative approaches to compensating patients who have been harmed by medical adverse events.

The debate around medical malpractice reform in the U.S. is clearly one which is very polarized, but there is one point on which virtually everyone agrees: that the current system is in need of reform and could be improved. We have been fortunate and appreciate the opportunity to have been working with the support of the Robert Wood Johnson Foundation and in collaboration with the Harvard School of Public Health to present some new ideas that can hopefully bring new life into the policy debate in this area and help break what has become something of a policy impasse in the medical malpractice debate. We're particularly interested in the potential of administrative approaches to compensate patients who have been harmed by medical injuries. With that in mind, I'm very happy to have with us this afternoon a group of distinguished and very well-informed presenters and respondents that we'll be hearing from.

We're going to start with a presentation from Professors Troyen Brennan, David Studdert, and Michelle Mello from the Harvard School of Public Health, who will give an update on the research that they've been doing about how best an administrative health court system might be designed in the U.S. Then, we're going to hear presentations from Carl Espersson and Martin Erichsen from the Swedish and Danish patient compensation programs respectively. Martin and Carl have traveled a long way to be here today, and we very much appreciate their being here. Then we're going to take a break, and when we come back after the break, we're going to hear a presentation from George Deebo and Kenney Shipley, who are Executive Directors of the Virginia and Florida Birth-Related Neurological Injury Compensation programs, respectively. Finally, we'll hear from a panel of respondents moderated by Troyen Brennan, which will consist of Steve Sleight from the International Association of Machinists and Aerospace Workers, Jackson Williams from AARP, David Swankin from the Citizen Advocacy Center, and Marty Hatlie from the Partnership for Patient Safety. I'm very much looking forward to their thoughts, and I know that they're going to give us some very thought-provoking comments.

Again, I want to thank the presenters and respondents for their time in being here and for their travels from near and far. I certainly again want to thank all of you for your time. We're so excited to have every one of you here. And I particularly want to express our thanks to the Robert Wood Johnson Foundation, for it is with the foundation's support that we're able to convene this event today.

With that thanks in mind, I'd like to introduce Jim Ingram, Senior Counsel at the Foundation, who will make a few remarks before we get going. Thank you very much.

(Applause.)

JIM INGRAM: Thanks very much. This is a wonderful turnout. It's very gratifying. I'm here on behalf of my colleagues at the Robert Wood Johnson Foundation. Those of you in the fields of health and health policy will know us as the largest private philanthropy in the United States that devotes its grant-making specifically to health and healthcare. Those of you from other fields will recognize us as the sponsor of All Things Considered.

One area of health and healthcare we have not been very much involved in the last couple of years has been the debate over medical malpractice and medical malpractice premiums, and I think that we have – standing on the sidelines – been a little bit disappointed in the quality of debate in this area, which has tended to focus on insurance premiums, on caps for damages, and on some very polarized debates over who is to blame for what everybody seems to agree is a system that is not working very well. And so we were very, very pleased and proud to be able to sponsor and to help put together this group of researchers from the Harvard School of Public Health and the very strong advocates from Common Good to take a really fresh look at this subject and to try to address not only the economic issues of damages and insurance premiums and the effect on medical economics, but also to focus on the areas of patient safety and quality of care in the hopes that a system of compensation will be able to contribute to reducing medical errors, to improving patient safety and improving the quality of medical care, things the present system does not do very well.

We pride ourselves on, whenever we sponsor an intervention that it's based on a sound research base, so I'm very proud and happy to introduce our research team who is going to speak to you now, Troy Brennan, David Studdert, and Michelle Mello of the Harvard School of Public Health. Thank you very much for coming.

(Applause.)

MICHELLE MELLO: I want to add my thanks to Paul for organizing what I think is really going to be a wonderful event, and also to our other speakers from Europe who have traveled very far to be with us today and share their experiences running systems that look like what we're proposing today. My job today is to talk about some of the research that we've been able to do on the idea of health courts because the Robert Wood Johnson Foundation and also the Commonwealth Fund have been willing to invest in this vision. We understand that vision is important and the fact that we have been able already to broaden the debate over malpractice reform, we view as a significant achievement.

But also important to all of you as you invest the time to consider this idea in your organizations, we understand, is the fine strokes around the idea and some evidence about what it would look like and how it would work. What would it cost? Who would make the decisions? Who has the most to gain? Who has the most to lose from a system like this? At our May forum, we began to have a conversation about some of those points. We had working groups of stakeholders and I know many of you were in attendance then. We talked about issues like governance. Who would be the decision makers? What is

the compensation standard? How would this system of compensation for injuries relate to patient safety and discipline? And how would access to justice be affected by this kind of a change?

We listened very hard to the ideas that were floated in that session, and over the last ten months, we've also had an opportunity to do a significant amount of research at Harvard and abroad. And what we're going to talk about today is some of the decisions and recommendations that we've come to as a research team, and also in consultation with our partners at Common Good, about what this proposal ought to look like in terms of the fine strokes. The proposal is always going to be a work in progress, both as our research progresses over the next year, and as the idea percolates through the states. We know that there will be changes and that the ideas will evolve. But, we think we've learned a lot already as a result of talking to folks who run systems like this, and also to folks who would be affected by it, and so we wanted to share some of that thinking with you.

When we spoke in May, really the proposal didn't go much farther than this – a set of core principles. And these are principles around which we've been building over the last few months and they are these. The first is that this is a non-judicial system. We call it health courts, but what we're really talking about is a primarily administrative process that would have elements of things from the judicial system that work, but that would be removed from the regular court system, and it would be specialized. We're talking about a system that is unique to disputes over medical malpractice.

Secondly, the compensation standard is not negligence. One thing that was very clear from our discussions in May is that no one likes negligence as a standard. It's difficult for attorneys to grapple with. It's difficult for doctors to grapple with and it's difficult for patients to understand. And the question then is, if not negligence, what? And we'll be talking today about an alternative, avoidability, that we think has worked well in Europe.

The third standard is that there ought to be decision guidelines of some kind, and those guidelines should be evidence-based. One thing that no one likes about the present system is that similar cases often come out differently depending on which particular juries hear the case and how the case unfolds. So we would like to talk about ways to incorporate decision guidelines that are developed in advance using evidence about medical causation that is processed and deliberated over by medical experts to guide decision-making.

The fourth principle is that there ought also to be some guidelines for damages. There is not too much work that needs to be done to improve the way we calculate economic damages. But there has been a great deal of talk in this country about how to deal with noneconomic damages in a more rational way. And we're of the belief that noneconomic damages probably need to be limited in a system in order to contain the costs and compensate a broader number of people, as we would like to do, but that a flat cap is a very crude way of going about that limit. And so we've been thinking quite hard

about what might be a more sophisticated way to limit damages and keep them sensitive to variations in the severity of the illness and other factors that might affect the way we think about fair compensation in a case.

Finally, we think that the compensation system ought to bear some relationship to patient safety improvement and we've been talking a lot about what opportunities exist to leverage information that is produced in the process of resolving disputes over malpractice, and also about how the compensation system ought to sit alongside other processes that exist to ensure the accountability of health care providers for care, such as disciplinary processes. And we'll be talking today about some of our preliminary conclusions on that. Also, our European colleagues will have something to say about how they deal with those issues in their systems.

So these are the principles that we've been working with, and they've led us to discuss a number of particular design choices. We raised these briefly at the forum in May, and we've gotten quite a bit farther along in our thinking about them. The first choice is jurisdiction – who should be covered and what is the locus of administration for the system? Secondly, who are the decision makers and what role do experts have? Will experts be the decision makers or merely help the decision makers? Third, what will the actual claims process be, and how much will it look like a trial versus an administrative process? Fourth, what's the compensation standard if it's not negligence? Fifth, how will damages be awarded? Sixth, what appeal rights will patients or claimants have in the system and who will be they be appealing too? Seventh, how will the system be financed? And lastly, again, how will we integrate this system with other patient safety structures?

As we've discussed our decisions around these points, we've developed a working document that we refer to as a system skeleton. This document is now available to any groups that are working or considering proposals for health courts. And Paul Barringer will be coordinating dissemination of that document, so let me start by saying that we've done a great deal more detailed thinking than we'll be able to cover in our presentation today. But wanted to share with you the broad strokes of our recommendations on each of these points.

As I said, we've been working based on our feedback from the May session, as well as a number of particular research projects that we've conducted over the last ten months. The most important of these has been our visits to other systems. We have had the opportunity in the spring to visit with colleagues in Sweden and in Denmark, as well as in New Zealand. We've also had a colleague of ours conducting interviews with representatives of the Florida and Virginia birth injury schemes who we're very happy to say are also with us here today to tell you about their schemes. So we've been trying to extract lessons about how well these systems have worked in general and how they would advise someone considering such a system. But we've also tried to drill down on very particular questions about how you move the compensation standard away from negligence, why you might choose to do so, what standard you would choose to move it to if you did, and how does it work? How do you actually make an operation standard

like avoidability work? What is the process that is used? How easy or difficult is it to decide the majority of cases, and what are the tools, guidelines, or mechanisms that have proved most important in making the system work well on a standard that is for us relatively unfamiliar?

In addition to the interview study, we've been conducting some legal research. We're very happy to have our colleague Ed Dauer from the University of Denver helping with this aspect of the project. Many state legislatures have raised questions about whether a move to a health court would be constitutional under the rules of state constitutions. There are also some questions about federal constitutional issues. Don Elliott at the Yale Law School is conducting an analysis of the federal issues, and we've been working on the state issues with Ed with the goal of understanding how courts in different states would approach a proposal like this. What would be the factors that would make proposals relatively more or less likely to succeed legally in different states, and what advice can we give in terms of relatively fertile or unfriendly state environments for starting demonstration projects? We hope to have a report out on the constitutional issues by the end of the year.

We've also been working on a preliminary model of the costs of the system. We've been using some existing data to try to model what the total system costs of health courts might be in a demonstration project. I should say that we have much more extensive cost analysis planned in the second year of the project, but this is a sort of back-of-the-envelope calculation for insurers or others who might be considering implementing a demonstration project.

The third set of projects that we have going is around operationalizing compensation criteria based on avoidability. And our colleagues, Allen Kachalia and Troy Brennan, and obstetricians at the Brigham and Women's Hospital have been working on a set of accelerated-compensation events for obstetrics and are now beginning work on a similar list for anesthesia. These are two possible clinical areas for starting a demonstration project. And the goal of these lists would be to define certain commonly encountered adverse events that would be presumptively compensable or not compensable based on a review of the best available medical evidence about why they happen and whether they're indicative of a preventable event.

And finally, David and I have been working on the issue of damages, thinking about how we might design a rational and defensible and equitable schedule for non-economic damages, an alternative to the flat cap that would take into account gradations in injury severity, perhaps also the age of the plaintiff, and be more sensitive to those kinds of variations that might affect the way we think about compensating particular cases. So this is the research that we're basing our recommendations on today and let me go through some of those recommendations.

First, with respect to administration, one of the threshold questions we had even within the team is should this be a federal system, a state system, or something that operates below the state level? And based on our trips abroad and conversations with

folks in Florida and Virginia, we recognize that broader systems have very significant advantages in terms of economies of scale, leveraging the best available human expertise, amassing cases in institutional learning relatively quickly. But we also recognize that there is a great deal of nervousness among those in the U.S. who would pay for this kind of a system. And based on that, I think our present recommendation is to push forward with small-scale demonstration projects that would be based at the level of an individual liability insurer or hospital or group of hospitals. In this way, we think we could build confidence in the system at relatively low risk and persuade the lawmakers that this is a kind of system that could work at the state level. A federal system is also possible, although, of course, it represents a deviation from the historical locus of control over malpractice law, which has been the states. But that is also possible, for example, through the Medicare program. There has been some discussion about the possibilities for a demonstration there.

The second question we asked with respect to jurisdiction is what kind of disputes ought to be covered? And here, we came to the conclusion that this should be a system for medical malpractice disputes only. There have been suggestions that the system might also encompass product liability claims, for example, drug-related claims alleging a design defect. And there have also been suggestions that coverage disputes or mixed treatment/eligibility claims against managed care organizations might properly be encompassed within a health court system. But having reviewed some of the case law around these kinds of disputes, our conclusion is just that the claims tend to be too different to be easily situated within a health court alongside ordinary or garden-variety medical malpractice claims. So this is a system that we envision being limited to the ordinary types of claims that doctors and hospitals face on a daily basis, not claims against drug companies or HMOs.

A second related question is should this system cover all clinical areas or only certain clinical areas? And again, in discussing with our colleagues in Europe and New Zealand their systems, we see very significant advantages to having a system that encompasses all clinical areas. One of the main reasons is that injuries often are not limited to a particular clinical area. They result from care by teams of providers that cut across disciplines. And for many specialties, it would be very difficult to carve out that particular specialty and isolate it from other providers. But again, in the spirit of thinking small at first and building a base of evidence, we think it's feasible to think about demonstration projects that would be isolated in a particular specialty. And the two candidates that seem most favorable to such a demonstration in our view are obstetrics and gynecology or surgical/anesthesia claims, because the types of events that result from these kinds of care tend to be fairly easily isolated, and even more importantly, because patients tend to have relationships with health care providers quite far in advance of an adverse event happening.

An obstetrician-patient relationship develops early in the pregnancy, for example, and this is significant because the kind of demonstration project that we're talking about would be an opt-in system. Health care providers would opt to be a part of the demonstration project, and any patient who is cared for by that health care provider

would then presumptively be covered by the system for any injuries that arose out of that care. So given that informed consent of patients would be an important component of the system, we'd want to identify specialties where the opportunities for meaningful informed consent exist. And those opportunities are most likely to arise when care relationships pre-exist the injury by a significant margin. So anesthesia for non-emergent surgery is another good example of where such a relationship might arise. The other advantage of these two particular areas is that we know quite a lot about patient safety and adverse incidents in these areas. They've been relatively well studied by patient safety researchers, so we're relatively well able to anticipate the kinds of claims that might arise and to understand important issues about causation and preventability and to apply that evidence to develop lists of adverse events that would be presumptively compensable.

On decision makers and the role of experts, this is another area where we had to make a difficult decision about who would be the decision maker, and in particular, we grappled with the question of whether the decision maker, himself or herself, ought to be medically trained. There have been many proposals for medical courts, dating back to the 1970s with proposals by the AMA, where you actually have a physician sitting on the court making decisions. And, of course, there are very significant advantages to doing that in terms of technical expertise. But we considered other alternatives. One would be a very heavily early-offer-based system, such as has been advocated by the Bush administration and others, where the primary locus of decision making would be at the level of the individual hospital or insurer, and there would be strong incentives for them to make early offers of compensation. The other model that we looked at is the administrative law judge model, where you have a judge who is specialized and experienced in the adjudication of medical claims, but is not himself or herself a physician or clinician. Rather, their decision-making is aided both by their own experience in specialized area as well as neutral court-appointed experts. And we thought that model had a great deal of appeal.

Our ultimate recommendation is to design a system that combines the early-offer model with what we would think about as administrative law judge plus model, where we have judges who are, again, very experienced and specialized in the adjudication of medical malpractice disputes, are heavily aided by medical experts, but they are not themselves physicians. I think the political advantages of this are fairly plain from a consumer's perspective. I think it would be greater assurance that there would be a neutral decision maker who would have consumers' interests at heart. But the extensive use of medical experts means that the decisions would also be much more informed than they are under the current jury system.

Now, to explain how these decision makers would fit together in this system, I want to pause here and turn things over to David Studdert who is going to go through the claims process.

DAVID STUDDERT: Thanks, Michelle. So a very central question is how would the system work from the point of injury through to a final determination on a

claim. And the way that we have been thinking about this at the initial level really doesn't differ a whole lot from the current system. The process would begin with the patient lodging a claim with the insurer or the insured institution. The trigger for this action, of course, would be an injury. That injury may be self-identified by the patient, but there would be a strong expectation in this system, indeed it would be one of the advantages of this system – we hope – that much of the identification of injuries would occur through disclosure of the events by providers to patients.

So the initial claim lodging would be similar in many ways to the tort system. But I would just signal at this first step in the process two main differences. One – claims will be made using a standard form, which would be easy to complete for patients and widely available to patients in participating facilities. Secondly, and a related point, the simplicity of this claiming process is intended to make retention of counsel optional, but not necessary at this initial stage in the process. A panel convened likely by the liability insurer or the health care facility would then render a decision on each claim it received. These panels would operate under a set of basic procedural rules issued by the health court. For example, there would be requirements around membership of the panel – relevant clinical expertise represented, no representation of providers who had a role in the care at issue, etc.

The panels would apply decision aids of the kind Michelle spoke about a moment ago. These decision aids would help them take advantage, both of precedent within this institution and across the system as a whole. The decision aids would also help bring the best scientific evidence to bear and have it readily available at the panel's fingertips. For claims that the panel determined were non-compensable, the panel would need to explain why. For claims judged compensable, the panel would make an offer of compensation based on a schedule of damages – and more on damages in a moment.

In both cases, accepts and rejects, the panel would file a summary of the descriptive statistics of the case and the outcome of the case with the health court. This would serve three main objectives. First, it would allow centralized tracking of claims, something that our current system simply doesn't do. Second, it would allow the building of precedents about compensable and non-compensable events system-wide, another thing our current system doesn't do. And thirdly, perhaps most importantly, valuable data could be accumulated on a wide range of injuries occurring throughout the participating sites, and these would be made available in redacted form to researchers for error prevention research.

Patients who were satisfied with the panel's decision –rather, dissatisfied – either on the compensability determination or on the level of damages they were offered could seek to have it reviewed by the health court. Now, we would not think about the health court's role here as an appeal in the classic sense. Patients would not need to meet a high standard for moving their case up to the health court. It would be automatic or virtually automatic on the patient's request for the health court's review of a decision. So it's a second level review, but what we're really talking about is a second look here by the health court. And we would estimate that a significant number of claims would move up

to this level. The health court would gather information from the facility, through queries to the patient and, as in worker's compensation, probably in some cases through an independent medical examination of the patient. The health court would then render a decision drawing heavily on the independent expert input that Michelle referred to.

For claims judged non-compensable, the court would issue an explanation much as the facility had done. The health court might echo the facility or insurer's rationale, or it might provide its own. For claims judged compensable, the court would make an offer of compensation. When a hospital's or insurer's decision to reject a claim was overturned by the health court, and the basis of the original decision was clearly wrong, the provider – that is, the institution -- may be fined. Similarly, when it was clear cut that an injury had not been the subject of a disclosure, and the injury was clear, fines may also be levied. Patients whose claims remain unsuccessful after the health court's review would have the opportunity for further review outside the health court system; this would be an appeal in the traditional sense. The appellate review standard, however, would be fairly high, as Troy will talk about in a moment.

A critical question in the design of a health court, arguably *the* critical question, is “what standard will be applied”? And Michelle touched on this so I'll zip through it pretty quickly. One of the main alternatives that we looked at was the standard now applied in New Zealand as of about six months ago, which is referred to as a “treatment injury”. Essentially, a treatment injury is any injury caused by medical care. Eligibility for compensation under this standard is not predicated on any inquiry about the quality of care given. Causation is enough.

The other leading option is preventability or avoidability. Under an avoidability standard, injuries that would not have happened were optimal care given would be eligible for compensation. This has some similarities to the negligence standard, but it's broader, and the avoidability focus does not zero in to the same degree on individual or provider fault. Now, the Nordic medical injury compensation systems have applied a version of avoidability for many years, and we'll be hearing about that shortly from Carl Espersson and Martin Erichsen.

We think that cost concerns almost certainly make a treatment standard unworkable in the United States. Our current recommendation is an avoidability standard and this ought to replace negligence as a threshold for compensation in the health court model.

A significant portion of the research we're conducting with support from RWJ is really aimed, as Michelle said, at operationalizing this standard. There's been plenty of good work done in this area already by Larry Tancredi, Randy Bovbjerg, and others. We're trying to link this work with the operational experience of the Nordic countries and New Zealand, and come up with a standard that works. And we think that the avoidability standard can work, at least as well and hopefully much better than the current negligence standard.

What package of compensation will be available to injured patients whose claims are accepted by the panel or by the health court? Economic losses would be compensated in full, we would recommend, with the exception of a short deductible period. Now, in fact, the deductible period really goes to the question of eligibility. Once a patient past a given duration of lost work time (in the vicinity of four to six weeks) or a certain level of out of pocket medical expenses (perhaps around the range of 3 to 5 thousand dollars), they would become eligible to lodge a claim. Now, the purpose of the deductible period is to channel the system's limited resources into the injuries that cause the most significant loss. Also, the system just simply wouldn't be cost-effective if it was inundated with claims over minor and temporary injury, claims that were worth less than the cost of resolving them. For injuries with long-term consequences, payments would be made periodically rather than in a lump sum, and the system would act as a second payer to health and disability insurers that already covered the claimant.

One of the most controversial issues is non-economic losses and how they'll be compensated. Many in the debate have been drawn to flat caps. As Michelle suggested, there is pretty good agreement among experts that flat caps are regressive in the sense that those with the worst injury have the greatest amount backed out of their awards. An important piece of the health court would be to schedule these damages, non-economic damages, and as Michelle suggested, we're trying to develop a basic framework for doing that. Essentially, the framework relies on a tiered system corresponding to the severity of the injury, and at the user end, what the decision maker would find is that each tier had a dollar range associated with it and they could select a figure within that dollar range, taking into account the circumstances of the case.

With that, I'll turn it over to Troy who will start in on appeals.

TROYEN BRENNAN: I'm mindful of the time, so I just want to hit a couple of the highlights here with regard to some of the other issues that we've considered. And I think, you know, the basis for this is we're trying to design a system that is fair and one that is efficient, so you'll see those issues coming through here.

With regard to appeal, we consider it arbitrary and capricious as opposed to a substantial evidence standard, and we think we would go with arbitrary and capricious. It's a reasonable standard for review of what is essentially an administrative determination and certainly one that we find elsewhere in the law. We think there would probably be less appeals, or less successful appeals, from an arbitrary and capricious standard. But we feel that is necessary.

Regarding the financing – thank you, Michelle – there is two different ways to go about it. One would be a social insurance model that would be financed through tax revenue. The other would be a privately financed model that utilized existing insurance arrangements. I think where we are on that right now is that although many of the systems in other countries use social insurance to finance a model, it is not one that we employ a great deal here in the United States. And given the nature of the experiments that we're suggesting, it's probably best to leave the overall private financing through

insurance mechanisms models in place. That also helps us to do experience rating and thus creating appropriate economic incentives. So we think a privately financed model is going to be appropriate.

The health court itself would be pulling cases out of the judicial system, so we think there would have to be some sort of appropriation from the state in order to get that started. But, just like worker's compensation, we feel like probably the state is going to end up spending the same money or less for administration in that regard. We're also very aware of the fact that if you're an insurance company that is thinking about participating in one of these, you're not going to know exactly what your actual costs are that are going to be associated with it, and so we probably will be looking for some sort of stop-loss guarantees from the government in order to reassure people who are participating.

And then finally, we want to think very hard about the relationship to other patient safety structures. It's interesting from our point of view the patient safety movement comes from the IOM report in 2000. It was based on a series of studies that were done to explore the relationship between medical malpractice and what was going on in hospitals, so the safety movement takes its birth from research that was essentially malpractice oriented. Thank God, it's gotten moving and moves on its own. But the question is how can the safety system be supported by and support the system for addressing compensation.

So there's a series of different alternatives. If we did have a statewide system, we'd have a state agency with responsibility for claims processing and safety improvement. If, on the other hand, for that first point, if we use private insurance companies – and mainly we think of the private insurance companies that would participate in this would be the forward thinking ones that are already using their information from claims to promote safety improvement. The second thing was whether or not we'd share de-identified claims data with patient safety organizations such as the new federally qualified PSOs.

Third question is whether we would put identifiable claims data with organizations responsible for physician discipline. This is perhaps the most controversial of the areas because that kind of information can lead to sort of strategic decisions. I was just speaking in Florida yesterday where they have three strikes and you're out, but those three strikes are if you go to court, so it's no surprise that no one is going to court. Everyone is settling out of court for claims. So we'd have to have some specific considerations as to where exactly this information would be shared with the licenser and disciplinary boards. Certainly, feeding claims back to a hospital patient safety office makes a great deal of sense, and also sharing it over with the FDA. So at this point, we think that we would probably endorse all five with potentially the exception of number three, and with regard to the first, probably involving the private insurance companies who would be participating in those safety efforts.

So we do have a reasonable amount of ongoing research. We're still looking hard at avoidability and trying to construct the accelerated compensable events – not an easy thing to do, and in certain areas nearly impossible. But certainly, with regard to some areas – obstetrics and anesthesia – that we're concentrating on, a place where we think we can make some good progress. We're looking for places that are going to be optimal sites for demonstration projects, and we're doing more extensive cost analyses, because we realize if this is a voluntary thing, then those who are participating voluntarily are going to have to be able to tell the people who they're insuring that their rates aren't going to go up significantly. And then, finally, there is the empirical model of scheduling of damages that we're working on at the present time.

We were supposed to be done at 1:40. It's exactly 1:40 on my clock here. But we might take just a couple of questions before we start in. So I see two hands went up, the fellow in the blue shirt and then one in the very back. Yes, you.

Q: (Off mike.)

MR. BRENNAN: Well, you've got to pick your best question.

Q: Okay, one. My best question, which is in this system, it's very important, as I understand it, to find – (inaudible) – verify the injury because that's the key to applying the various avoidability considerations and damages. I heard you say that you wouldn't do an IME if you went up to the panel. Wouldn't you want some kind of initial screening to verify and validate the claim of injury particularly if the patient makes it?

MR. BRENNAN: Well, and I think it's – and it's a good question. It's a very good question. And you might want something like that. I mean I think what we're going to want to do is sort of try to put a framework in place and then, depending on which states and who is interested in participating in it, work with them in terms of how they would see things best processed. But the idea that there is an initial verification that an injury occurred is probably a reasonable one, and certainly something that we would consider. I don't want to give you the sense that we have thought through sort of every detail on this. We could certainly come up with a detailed answer to something like that, but more what we want to do is leave it a bit plastic so that people can work with it.

And in the very back.

Q: Yeah, in terms of the –

MR. BRENNAN: You're going to have to speak up.

Q: In terms of the qualification for these – (inaudible) – administrative revenues in a system like this, the previous speaker mentioned that the – (inaudible) – particularly when we have an MD as a department head that does not – (inaudible) – position qualifying – (inaudible) – and the other follow-up question, does one have to be an attorney to qualify – (inaudible)?

MR. BRENNAN: Right. I think it's a little bit of an open question. But if I had to sort of share my bias with it, the health court has got to reflect sort of fairness as much as it reflects expertise, and so at that point, you probably go with someone who is concerned about procedure more than someone who is concerned about specific expertise, so long as that individual is flanked or associated with that impartial expertise. So I guess if you had to ask what my bias was, I'd say the bias would be more in the direction of someone who is trained in the law. Okay, all right, we can ask one more question, because those were fast.

Q: Can you articulate why you decided to go after the malpractice situation in general as opposed to one defined area like obstetrics where we know the outcome that leads to the vast majority of suits? You can do a no-fault approach, a true no-fault approach, and avoid the cumbersomeness of the judicial system and even of the health courts.

MR. BRENNAN: Well, I think if we went after obstetrics, for example, we'd still go with something like avoidable injury, or we'd still go with sort of an accelerated compensable event approach, and you'd still have the health courts involved. We have debated amongst ourselves and with a variety of other people about whether or not we should try to look comprehensively at malpractice or specific specialty areas. Obstetrics and anesthesia come to mind, some places where you can get around some of the consent issues. And I think as Michelle mentioned, it was one of our considerations to do that, the more specialty-bound approach. The only problem with it – but I think it's a big problem – is that you get into border issues. And as we'll see when we talk later, things spill out and into the malpractice system. And so, if you look at other administrative type claiming, people have generally been more comprehensive rather than specialty bound. But if states said that we'd really like to attempt this approach, how do we incorporate health courts into that that would be a specialty bound program, we'd be interested in talking with them about that.

Okay, thank you very much.

(Applause.)

(Break.)

CARL ESPERSSON: Well, I'm very thankful for – to Paul Barringer that asked me to come all the way to Sweden to your beautiful capital here in Washington to tell you something about the Swedish patient insurance scheme. And I like to start here and tell you how the situation was in Sweden before we got the patient insurance scheme.

At that time, it was in Sweden like in the rest of Europe and in America that you had to hang a doctor to get compensation, so you had to prove negligence, error or omission, and that was very difficult in Sweden. It was very difficult to get doctors that could help patients in court. We don't really have the system you have with expert

witnesses. And it was very time-consuming and also a very costly process for the patient and also society. And up till 1975, it was only in about 100 cases in Sweden per year that compensation was rewarded by the courts. And it could be good for you to know that we have about – a little over nine million inhabitants in Sweden.

And then sometime after the Second World War, there was a discussion in the Swedish parliament about better compensation rights for patients, but the matter was then regarded as so technically complex because there was nowhere in the world where you had a special system of this kind to devise suitable roads that the authorities – they'd react to the establishment of extended liability in law.

But then in the '60s and the '70s, we had in Sweden, like the rest of the Western world, great expansion of health care, and that meant that an increased number of operations could be performed on patients in high-risk groups, and also larger and more comprehensive surgical intervention were performed. And of course – so one could give much more health care to the population in Sweden, but of course then there would also be more complication.

And at that time – and that was long ago – at that time, Sweden was one of the richest countries in the world, so at that time we thought that we could afford a system like this. So the county councils in Sweden then started to investigate if we could have a voluntary scheme in Sweden and the councils, they stand for about 95 percent of health care in Sweden, so most of the health care in Sweden is owned by the public. And they, together with the ministries of Justice and Health and Welfare, they started – together with the four biggest insurance companies in Sweden, to investigate if we could have a scheme. And that also happened in 1975, the first of January – we got the voluntary patient insurance scheme.

And it is sometimes said it's a no-fault scheme, but that's not a really good word for it. It's better to call it a no-blame scheme, so it's something in between tort law and strict liability. And the insurance – the patient insurance, first it was the county councils, but after a few years, 99 percent of the health care were covered by this voluntary scheme. And it's – the insurance is paid by the healthcare provider, and that is mainly the county councils, so it's tax money in there and that pays for it.

With this system, we have a compensation on more objective ground. We are not looking for scapegoats anymore, and the time for decision is comparatively quick -- and I will come back to that – and it's also free of charge. That is the difference between United States and Sweden. You have contingency fee here in the States, but we don't have that in Sweden or Denmark, that would pay the lawyer by the hour. And the thing is if you lose a case in a Swedish court, you have to pay your own lawyer, but also the other side's lawyer, so that can be rather expensive. In a normal case, that could cost a patient about \$30,000. So that was very important for – with our scheme, that it should be free of charge.

And today, about 5,000 patients are compensated each year, and when we got this scheme in Sweden, you could say that since the introduction of the patient insurance scheme, the liability issue has been separated from the compensation issue, so we have a Berlin Wall there in the middle, and that is very important because all the information that is in the patient insurance scheme stays there; it doesn't automatically go over to the disciplinary side.

That is very important then to stress that this has meant that you have an increased confidence, an openness between personnel and patients, and we think that in about 60 to 80 percent of the cases – and 80 percent is more likely the right figure – of the reported cases, it is a physician, a nurse or a social worker that has helped the patient to make his claim, and when we tell the Americans about this, they are very surprised to hear that. And that is the situation in many other European countries like in Britain. If a doctor will help a patient to make a claim, he loses his insurance coverage.

And also it's – an important thing here, it's – from the patient point of view it's a feeling of redress because today when we are finished here we go home, and if we go home by car, we know we can have a car accident; I mean, we don't think about it all the time, but we know that's a risk – everyday risk. And the same thing is if you have a dangerous job, you are a construction worker, that there is absolutely no patient that's going in for operation that's thinking about patient injuries. So when this happens, it's always a big shock for the patients, and therefore it's very important that you have a fast claims handling and they can get their money because it's – when they get the money that they can go on with the life.

In Sweden, if a patient is not satisfied, there are different ways or different things that he can do. In many cases, it's just problems in contacts' attitude. The patient thinks that the doctor has been rude or that he has been – had to wait too long for operation or something like that. Then in Sweden we have independent patient advisory committees in every region in Sweden – it's about 20 of those – and they try to solve the problems in contacts, in attitudes, trying to bring the doctor and the patient together, and try to explain what has happened and what hasn't happened. We have about 25,000 of those cases.

And then we have the patient insurance scheme. We have about 10,000 claims each year in Sweden, and 5,000 are accepted. And then we also have disciplinary action against staff, then we have to go to the health and medical care liability board. They have around 3,000 reports every year, and in the – around 10 percent, 300 cases, the doctor gets a reprimand.

In the Swedish system, most of the claims handling is taken care of by the insurance companies, and as I said, county councils stands for 95 percent of the health care in Sweden, and they have their insurance companies. It's one – you could say it's mostly one company that takes care of all the claims. And after that, if you're not satisfied with the decision of the insurance company, you can take your case to a national board, the patient claims panel in Sweden. It's a board with specialists, lawyers and doctors, and even politicians that sit there. And then even in Sweden in a few cases, if

you want to, after that, you can take your case to court, but that's one case out of a thousand claims, so it's very seldom they go to court, but even in our system, you have that right.

And what are the pros of going this administrative procedure? Well, you have low costs per case for claims handling – I will come back to that – and also a short time for claims handling. And as I said before, there was no economic reason for patients like going to court in Sweden. And these are the – what it could cost.

We think that if you take a case first, then, to the insurance companies, it would cost the company about \$1100 per claim, and if the patient is not satisfied, he takes his case to a claims panel, the cost of that would be about \$1200 U.S. But then you see, if he still wants to go on, and he wants to go to court, then the cost is something like 27,000 to 30,000 U.S. dollars. And if the patient loses, he has to pay that himself.

And how long does the claims handling take in the – at these insurance companies? From the time the patient makes a claim to the time that he will get a decision that compensation can be paid out or not, well, he will have a decision within six months in 50 percent of the cases, and as you see, in 80 percent of the cases, he will have a decision in a year. And that is, I mean, much faster than if you go to court. At least in Sweden it takes a couple of years there.

It's important to mention here that why we can afford this system in Sweden is because we have an extensive social welfare system in Sweden, so if somebody is on sick leave, and no matter what the reason – it could be patient injury, traffic injury, work injury, bad back or a flu, or whatever – the welfare system covers 80 percent of the salary during sick leave up to an income of \$39,000 U.S. And if the person is – has to retire because of the injury, 64 percent is paid from the welfare system, and that means that if you have a patient injury, the patient insurance just comes and pays on the top and therefore is not so expensive as in other countries where you have to pay from the first crown, and that's the reason why countries – many countries outside the Nordic countries don't have it (in Europe ?) because there they would have to pay from the first crown. It would be too expensive in many countries.

I could also mention here that the cost for medical care is very low for now Swedes. We pay almost the highest taxes in the world, but we get something back, and when we go to hospital, we only pay \$15 a day for a hospital visit, and that includes if I have to go through open-heart surgery or be in intensive care unit, or anything like that. It's 15 crowns a day; the rest is paid by the state.

And if a Swede has medical costs or costs for drugs that are over \$350 a year, then over that amount the state pays for most of it. So if you have an injury in Sweden, a lot of it is paid by the welfare system. So that could be good to know. That is one of the reasons, I guess, that we can afford this system in Sweden.

In the beginning in Sweden, it was a voluntary scheme and it covered about 99 percent of the health care in Sweden, but the government thought that it should be a compulsory system, so all patients should have the same right. So in 1997, we got the patient injury act, and the rules are more or less the same as in the voluntary scheme. But with this act then, every health care provider in Sweden is required to have patient insurance.

But then one can wonder what happens if a private doctor for some reason has forgot to have patient insurance and there is an injury. Well, then the patient can take the case to the patient insurance association that will investigate and compensate the injury. And all insurance companies that issue patient insurance, they should belong to this association, and then if they have paid out compensation, then they can reclaim that compensation from the caregiver and the caregiver also has to pay a penalty for not having a patient insurance. But this is a guarantee that all patients that have patient injuries should be compensated.

Now we come to the tricky think here – patient injuries: what are those? And it's very difficult here in just a few minutes to say something about it because this is very technical and I guess one can stand here for a day or two and talk about it, but I will just say that – say something about the different groups.

First we have a – we have six different groups because we look upon them a little bit differently. First we have what we call treatment injuries, and here we say that when a treatment injury has occurred, the patient should be indemnified if their injury could have been avoided if the treatment just as effectively could have been applied in another way. So here we are talking about avoidable and unavoidable injuries. And the standard we are looking for is the experienced specialist in the field, so if I have a hip operation and there is nerve injury, we ask ourselves if it had been an experienced specialist here, an experience orthopedic surgeon, could he at least theoretically have avoided the injury, and if the answer is yes, even if there is no negligence whatsoever, compensation can be paid out. And the assessment as to whether the injury could have been avoided under the circumstances that existed is done after the fact because it is done during the claim sounding because sometimes you could say that if the complication is due to lack of knowledge for the surgeon of a special deviant condition in a patient, compensation is to be paid out if the injury could have been avoided if the surgeon had known about it. So if the nerve – the special nerve was in an area where it usually isn't, compensation can be paid out because with the knowledge we have in hindsight, we could have avoided that injury.

When we had our friends from America visiting us, they always ask, you know, give us examples, and so on, but it is rather difficult to give good examples because one case is not really like the other one, but we usually say that nerve injuries are good examples when it comes to this question of avoidability. And we quite often can see injuries due to vocal chord nerves, that they can arise in regard to thyroid surgery, and here we say that those nerve injuries are usually avoidable when you have all the facts afterwards. If it's not a matter of reoperation because if you have a reoperation in the

area, you can have scars from previous surgery, and it's impossible to identify the nerve, and then it cannot be avoided. And the same thing if you have cancer surgery. In cancer surgery, if a nerve is covered by a tumor and you have to take away the tumor, then you cannot avoid to injure that nerve, and it might also be a part of the operation to cut that nerve.

Sometimes you also see during operations compression to some of the nerves – to the noris (ph) or peroneus nerves caused by pressure as a consequence how the patient has had his arm or leg placed during operation, and those are often looked upon as avoidable injuries.

I don't think there's more really I could say about it right now here, so – but this is the big group, and this is our trouble area because, for many cases, we have good guidelines, but the medical field changes all the time so what is unavoidable today is avoidable tomorrow, so things change sometimes rather fast here.

The next group is material-related injuries. Here you could say it's more like product liability. Here we say compensation can be paid out if the injury is caused by a defect in or a defective use of a medical/technical product or hospital equipment. But we have very few of these cases. When I started to work with this I thought that we would have quite many, but they are very few – one in a thousand claims or this kind.

But the next group is a group that has grown very fast in Sweden – diagnostic injuries, and here the rules are rather similar to the old fashioned tort rules. Here we say that compensation can be paid if the injury was caused because an actual observable symptom was ignored during diagnosis or was interpreted in a manner that deviated from normal standard applicable to an experienced specialist. So here we have the experienced specialist again. But this is a big group in Sweden.

But then we have infection injuries. Here you could say when it comes to infections that insurance has partly acquired the character of pure complication insurance, so the prerequisite here is that if you have transmission of an infectious agent from the outside during operation then the compensation can be paid if the infection is of a certain severity.

And then we also have – and I can say that the reason why we got patient insurance in Sweden – one of them was that there was a lot of media coverage in the '70s about hospital infections.

And then we have accident-related injuries. If you have an accident that is in some way related to the care, compensation can be paid out.

And the last group here is medication injury. Here we have tort law rules. Here we say that compensation, if caused by the prescription or administration of the medication in conflict with rules or guidelines. But here I must stress that in Sweden we have a sister insurance that is called a pharmaceutical insurance in Sweden, and that

insurance can give compensation for side effects of drugs, even if they are well known, if they are of a certain severity.

What kind of compensation can we pay from the Swedish scheme? Well, first of all, the idea is to pay a hundred percent compensation for loss of income and additional expenses, and as I said before, much of that is paid from the welfare system. And then compensation can also be paid for non-economic losses like pain and suffering, and so on, and here we don't have the – it's not at all as in the United States. The maximum you can get in Sweden today would be about \$220,000 for non-economic losses. That's the cap; that's the limit.

And then also we have a few cases of those that we compensate in 1-1/2 percent – something like that – the person dies and then of course funeral costs can be compensated, loss of support if it's the one with the highest income that dies, and also special contribution to the next of kin as a kind of non-economic loss for the grief of somebody close that has died.

Like I said before, it's first – if a patient wants to make a claim, he first has to go to an insurance company, and if he is not satisfied with that, he can go to these national board we have in Sweden. That's where I'm working as a legal adviser to the patient claims panel. It's an advisory body, but the insurance companies – they always follow what the panel comes up to, and then in a very few cases. So here you could say up to the panel – that's 99.9 percent of all claims, but one in a thousand – something like that – can go to court also.

Before – in the beginning, when we had a voluntary scheme, instead of court then the last resort was arbitration, and there perhaps we had about 40, 50 cases each year, and so that worked rather well.

Some statistics here – claims statistics. As I said before, we are about 900 million – 9 million inhabitants, and we have 10,000 claims; 5,000 are accepted. Of those claims that – where the patient – they are not satisfied, 1,000 of those claims goes to this panel, and the panel makes another decision than the insurance companies in about 10 percent. And then we have something like 5 to 10 court cases each year. It's only one or two of them where the court rewards compensation.

The cost of the Swedish system is about \$60 million each year, and then we have also here the claims handling. The cost for that should be something like 9 (million dollars) to \$12 million.

It could be interesting for you to know where things happen in Sweden and patient injuries mostly happen then in sectors with a large volume of operations. These figures are from '97 to 2001, but it's exactly the same today, and then you see the biggest group here where we have claims is orthopedic surgery – 21 percent of all claims and 23 percent of the cost; and general surgery is 15 percent of the claims; 13 percent of the cost.

But then you could see then when we come to obstetrician and gynecology it's 8 percent of the claims, but it's 25 percent of the costs, and as I said before, that costs in Sweden are mostly covered by the welfare system, so if we hadn't had that welfare system in Sweden, that would be a very high figure.

And then last year you could see dental clinics, 11 percent of the claim but only 2 percent of the cost, which means that dental injuries are not that severe.

Reported injuries – are those the top of an iceberg or not? Well, there has been investigation in Denmark in 2001 and in Canada in 2003, and they came to the conclusion that real number of avoidable adverse events are approximately 2 percent of all in-patients. But of course many of these figures are, you know, very small minor injuries, but something went wrong that could have been avoided. And according to the Scandinavian patient injury insurance, it is 0.2 percent of in-patients make a claim to the injuries. See, even in our systems, we don't get all cases. But I think that you could say that in Sweden all severe injuries are reported.

It could also be interesting to know that we have a big database in Sweden now with claims – 150, 1,000 claims in a database. And each year the individual clinic receives a report of the clinic's own injury statistics compared with the national figures. So the chief of the clinic, he can say perhaps it has twice as many infections as other clinics of the same kind, but on the other hand, perhaps not so many nerve injuries or diagnostic injuries. So this is the feedback the system can give.

Well, are there weaknesses in the system? Well, there I guess are many. But I think that the main ones are that avoidability criteria is difficult to understand for outsiders that patients always think that if I have injury of course it must have been possible to avoid it. And also injuries due to insufficient information or failure to obtain consent, they are not covered by their Patient Injury Act so there the patient has to go to court according to tort law system to get compensation.

So what is good about the system? Well, it's of course much easier to get compensation from the patient's insurance scheme in Sweden than it was before with the tort law system. So like I said today about 5,000 people are compensated. And if we still only would have had the tort law system, we figured that about 300 patients would be compensated according to the tort law system. And the compensation is then on objective grounds. The rule of evidence is more liberal in the Patient Injury Act than according to tort law.

And the procedure as I said before is free of charge; no economic risk for the patients, short time for claims handling, and low administration costs. The cost in Sweden is about 15 to somewhere between 15 to 20 percent more 15 percent. So when we hear that about 70 percent of the money put into the system in America – 70 percent goes to administration and lawyers' cost, it is very surprising because we always look upon Americans as, you know, very efficient and very fast – (laughter) – and when we hear those things we get very surprised. (Laughter.)

And the last thing also, with a system like this in Sweden, you have better relations between personnel and patients. And many times if a doctor has done something not so good, it really helps a patient and they can still have a good relation. So thank you very much.

(Applause.)

MARTIN ERICHSEN: Okay, I hope you'll manage to stay alive for at least 45 minutes more. Like Carl, thank you for inviting me here to Washington to tell you about how we compensate these cases in our administrative system in Denmark.

Before I start my presentation, I'll like to give you some facts about Denmark. Denmark is like Sweden, a very small country. Denmark is even smaller. We have a population on 5.2 million. One-fifth of the people in Denmark are living in the capital Copenhagen, like I do. But although small, Denmark is divided up in 16 counties and each county is running one or several public hospitals.

We have a tax-paid public healthcare system in Denmark. We have free access to treatment in public hospitals for everybody and free access to most of the doctors and specialists in private practice too. They are compensated by the state. Ninety-eight percent of all hospital beds in Denmark are in public hospitals, and we have in the public hospitals about 1 million discharges every year.

(Showing the first slide)

This is what I am going to talk about for the next 45 minutes. (Laughter.) There is a minor crisis between this patient and his doctor. The patient is of course claiming for compensation. Kroner is the Danish currency, but over here it will be a dollar sign I'm sure. (Laughter.) We have, like, Sweden, found what I find is a fast and easy way to solve this problem between the doctor and his patient. As you can see the doctor does not know the system; he is still sweating a little.

The systems in Denmark and Sweden are very similar. Actually we adopted the Swedish system in Denmark. Our system started in 1992. In Sweden they started a voluntary system in 1975. But there are still some major differences between our two systems. We have made some important changes. But I will, like Carl, start to go a step backwards, and see what the system was like before Patient Insurance Act was put into force in Denmark in 1992.

We had like you have here in the US – and what they have in most of the rest of the world a system built on general tort law. It's a system built on a principle of fault. The physician is only liable for the injury sustained if it is a result of a negligent act or an omission. The onus of proof of the physician's negligence and the correlation between this negligent and the injury sustained is on the patient. A system like this has two main

objects: to redress the patient or to put him in the same position economically as he was before the injury took place and to prevent injuries like this injury from happening again.

In the late-'80s it became more and more clear in Denmark that current system was not very effective when it came to compensation of treatment-related injuries. Only a very few injuries were compensated each year; only a very few claims were filed on the liability insurance companies of the hospitals. And when it came to prevention there was a lack or need of a central body to pick up knowledge about the processes leading to these injuries.

It is a long way to compensation in a tort-law system, and it was in Denmark too. What we actually did in Denmark before 1992 was that we made a shortcut, a kind of a shortcut. We have a public Patients Complaint Board. And what the patient looking for compensation did was to complain on the doctor to the Patients Complaint Board, and then he sat down and waited for the Patients Complaint Board to investigate his case and to make a decision. That was all free for the patient.

The result of the Patients Complaint Boards decision was either criticism or not criticism. If they found basis for criticism, often the patient was compensated by a liability insurance. If they did not find reason for criticism – that was in 80 percent of the cases – there was no compensation and the patient had to go to the court system.

The major problem with a system like this and with a system like that you have in America now– and it's really rather odd – is that the patient often can not tell whether the injury he suffers from is caused by his underlying disease or by the treatment. That seems a little odd but it seems often to be the case.

I can give you an example. A young man is run over by a car. He is only having a fracture on the lower end of his leg. He is brought to the emergency room with this fracture. His foot is in a malposition. But they put his foot back into the right position again, and even though the best specialist would then have fixed his fracture with an internal or external fixation apparatus, the doctor in the emergency room only fixed it with plaster.

At the end of the treatment, the patient ends up with a poor result. The foot is still in a malposition. But what does the patient think? Well, he thinks: "Well, I came to the hospital with a foot in a malposition, now I have a foot in malposition. The doctor did whatever he could; he couldn't help me. My injury is caused by the traffic accident and not by the treatment I have received."

And that is essentially one of the major problems with a tort law system. Many patients are not aware that they suffer from a treatment-related injury. They never file a claim, and therefore they are never compensated. So what we need to do is, that we need the doctors to help the patients to file the claims. Another problem is that the onus of proof is very hard for the patient. How shall a patient know what it is right and what is wrong when it comes to medical treatment.

In the system we had before the patient needed to complain on the doctor to get compensation. Our experience is that most of the patients do not want to complain on the doctor. They have this experience that the doctor did whatever he could, but it went wrong anyway. "The doctor is not at fault, but I want compensation anyhow." And another problem related to this is that the treatment is often still going on. The patient has to face the doctor the next day, so they don't want to complain on the doctor.

Court cases mean a great delay in the compensation process. Before 1992 the Patient Complaints Board in Denmark had a case-handling time on an average two years. Eighty percent of those cases were declined and had to go to the court system, for another two to four years in the court system. It is a very slow process.

We reinvented what Sweden had already invented, this two-line system that Carl talked about with the Berlin Wall between the systems. We have the compensation system on the one hand and the complaint system on the other hand. And what is essential is that there is absolutely no exchange of information between those two systems. You can file a complaint to the complaints board and a claim for compensation to us, Patient Insurance Association, at the same time. Actually about 20 percent of the cases in the Complaints Board are also in the compensation system with us.

The separation of the two systems is the only way to ensure that the doctor has an interest in helping the patient filing the claim. And if the doctors do not tell the patient that the injury they are suffering from is a treatment-related injury, the cases never come to compensation.

The next step we took was that we created an insurance scheme that in outline, from a technical point of view, is a tax-paid system where the healthcare provider takes out the insurance. As I told you we have 16 counties in Denmark. These counties are responsible for all care within the county area. They are even responsible in accordance with this insurance system for the treatment going on in private doctors' clinics and in private specialists' clinics. They are paying the compensations fixed by us, and the administrative costs for us, the Patient Insurance Association, and for the appeals board.

The patients do not need legal assistance. We have now in Denmark 40 lawyers looking out for the best interests of the patient in the Patient Insurance Association. We claim ourselves to be an independent body, and our responsibility is to receive, to examine, and to decide in all claims. It's an absolutely free system for the patient, and there is absolutely free access to appeal to The Public Appeals Board.

Furthermore, it is a compulsory system. The patient cannot choose to go to court. He has to go through this system; has to file the claim to us. If he is not satisfied with our decision he can appeal to our appeal board, but all that has to happen before he can go to court. So he cannot choose the short way to court; he has to go through our two level system first. One of the main ideas by building the system in Denmark was to avoid court cases because they are – very slow for the patient and very expensive for society. The court cases are tax-paid too.

From a legal point of view, all preventable or avoidable injuries are covered, and even some medical mishaps are covered if specific conditions are met. The patient does no longer have to go to court to establish that a healthcare professional has acted negligent. Fault or negligence is no longer a condition for damages. The onus of proof is still on the patient, but it is made less stringent. He does no longer have to prove the correlation between the treatment performed, and the injuries sustained, only that the injury is more likely a consequence of the treatment.

Is it a no-fault compensation system? I have reached the same conclusion as Carl. I think it is not a purely no-fault system. It is not a system that provides compensation on a purely no-fault basis. There are still conditions to be met for the patients to be entitled to damages. It is a system where the focus is moved away from blame away from the individual healthcare professional and towards compensation. So, like, in Sweden we call it a Nordic no-blame system.

Of course we have limitations in the scope, and that is why it is not a purely straight liability system. The patients' underlying disease is never covered. That seems to be fair to all of us. Only injuries that are more likely caused by the treatment are compensated and the standard of proof is preponderance of probabilities. It is not a guarantee scheme. Damages cannot be paid for the simple fact that the treatment did not have the expected effect on the patient if the treatment must otherwise be regarded as uncomplicated.

We have conditions for damages in Denmark. They can – as they are laid down in the Danish insurance scheme - be divided up into two main groups. On the one side we have injuries that could have been avoided by the best specialist, if the technical equipment hadn't failed, or by the use of another treatment method. And on the other side, we have the unpreventable injuries or accidental injuries, if you like, that are rare and more extensive that the patient must reasonably endure.

These were the decisions we made in 2004. It can be a little hard to read from back there. But we approved 43 percent of the cases that we received in 2004. That is roughly half of the cases we received. And of these 43 percent, half of them were approved in accordance with the specialist rule, the other half in accordance with this durability rule for unavoidable injuries.

So I will stick to tell you about the specialist rule and the rule for unavoidable injuries - the durability, and then I will leave to you to read about the other two provisions, the equipment failure rule and the alternative technique rule on our web page www.patientforsikringen.dk because they are still interesting but less important in Denmark.

The specialist rule is a very high-liability standard. All treatment performed is compared to what could be expected performed by the best specialist in the field in question. The question is whether the best specialist under the same circumstances would have provided a different treatment by which the injury in all probability would have been avoided. If the answer is yes, the patient is entitled to damages. All focus is on the treatment, not on

the healthcare professional – no names are mentioned in our decisions and that is very important to us.

So what we do is that we instead point out how the treatment deviates from the best practice standard, and why we find that this deviation has led to the injury. Compensation is paid if the injury is caused by a deviation from best practice standard. What does this specialist rule cover? It covers of course all kinds of medical errors, all deviations from recognized guidelines, all injuries that would have been compensated in the old tort-law system – examples are erroneous diagnosis; for instance, fractures being overlooked in the x-rays – treatment omissions, the patient's disease having been overlooked despite his relevant systems. An example of such an omission is cancer patients who have systems of cancer but are not treated in the right way. The result of this is that there is a delay in the treatment process, and a constant poor recovery, prognosis for the patient.

The new thing with this specialist rule, when you compare to the old tort-law system, is that even those medical mishaps, where the treatment is performed up to a reasonable standard of care and skill, but not in accordance with the best specialist standard can be compensated.

I can give you an example again. If a patient is operated for a slipped disk in his back, it is acceptable standard in Denmark to perform an x-ray before the operation and then to make a pencil mark of the right level of the operation on the patient's skin, and then afterwards to operate the patient where the mark is. The best specialist standard is however to perform another x-ray during the operation, with the patient on the operation table to ensure that the operation is performed on the right level. So if this extra x-ray is not performed and the patient is operated on a wrong level, then he can get compensated in accordance with the specialist rule. He would have no chance to get compensation in the old tort-law system.

And then the new invention in the Danish system: the durability rule. And this is very important because half of the patients that are compensated in Denmark are compensated in accordance with the durability rule. It is unlike in Sweden and it is unlike what you're suggesting in U.S. I can see. But politically it is very convenient to have a way to compensate unavoidable injuries too because some of the unavoidable injuries are very severe to the patients.

It is a kind of catch all rule in the Danish patient insurance system, and it applies to unavoidable injuries that could not have been avoided by better treatment, by better equipment, or by the use of another method. The central condition is that the extent of the injury must exceed the level, which the patient must reasonably endure. The durability criterion is only met if the injury is both relatively serious and rare.

And what do we mean with this relatively seriousness? What we do is that we are making a weighing on the patient's underlying disease on the one hand, the necessary treatment and the risk connected with this necessary treatment of the patient's underlying disease,

and on the other hand, the treatment related injury. And as a rule of thumb, if the patient would have been better off without the treatment then he is entitled to compensation.

That means that the greater the seriousness of the patient's underlying disease, the more extensive the necessary treatment is; the greater risk connected with the necessary treatment, the more the patient must endure without being entitled to damages. Some diseases like certain brain tumors, certain severe heart diseases, and most of the cancer disease – if the patient is hit by an unpreventable complication in relation with the treatment of such a disease, the injury cannot be compensated in accordance with the durability rule.

The rarity criterion means that the injury only meets the rarity criterion if it occurs in less than 2 percent of equivalent patients undergoing the same treatment. And the idea is that the greater the risk of the occurrence of the injury, the greater the possibility for the patient to take its occurrence into account in the consideration of whether or not to accept the treatment. So you can say he has in some way accepted the risks of complications that happens often.

The best example of unavoidable injuries is in Denmark with the cleaning standard we have chosen to accept in the Danish hospitals – it is not very high I can tell you – is treatment-related infections. About 20 percent of the cases that we accept and compensate in Denmark are treatment-related infections. We know that patients undergoing hip-joint operations – a little less than 2 percent of those patients will have treatment-related infections in the joint.

In most cases, the infection is not very severe and as the operation is rather big the patients will not be entitled to damages. But for some patients the infection is very severe. They have this deep infection in the hip joint, it is necessary to remove the joint, it cannot be replaced, so they end up in what we call a girdle stone situation without a joint, and they are almost linked to a wheelchair for the rest of their lives. They can be compensated in accordance with the durability rule. And that is like I said – politically very convenient to have this possibility to compensate great injuries like this, even when there is no one to blame.

What can be compensated? Medical expenses and other losses, lost wages, and pain and suffering in the acute phase, and when the situation is stabilized, we can pay compensation for non-economic losses like permanent injury and loss of ability to work, and if the patient dies as a result of the treatment, loss of breadwinner, and burial expenses.

And like in Sweden, the main idea is to redress the patient or to put him in the same position as he was before the injury took place, not to make this patient very rich. We have this tax-paid healthcare system, besides that we have a tax-paid social security system. This social security system covers around 80 percent of the patient's losses in this case. So it's kind of "on the top" compensation like in Sweden, and that is the reason why this system isn't very expensive in Denmark.

Since 1997, the number of claims that we have received in the Patient Insurance Association has more than doubled. This year we expect to receive 5,200 claims. And with a population of 5.2 million inhabitants, it is one claim per each 1,000 inhabitants. I think this is the highest claim rate in the Nordic countries. And we actually consider this as a success. Because as Carl said earlier, we know from investigations, that we only see about 10 percent of the cases that could actually be claimed to our system.

The compensations we are paying out, are not nearly as big as they would have been in the U.S. Damages together with the administrative costs for the Patient Insurance Association and the Appeals Board, amounts up to \$72 million this year, and this is less than half percent of the total healthcare costs in Denmark. So it is actually a low-cost solution.

There are major strengths of a system like the one we have introduced in Denmark. From the patient's point of view, it is a great extension of the injured patients access to damages – 25 times as many patients are compensated today as was the case before this system was put into force in 1992 – 25 times as many.

It is easy and it is quicker way to compensate patients. The average claim handling time from the minute we receive the claim in Denmark until we make the decision on whether the patient is entitled to damages or not is seven months. And if we find the patient entitled to damages, he only has to wait another seven to 10 months to be compensated. So it is a very quick access to compensation.

There is no expense for the patient as I have said before, none at all; it's a free system, and the patient can rely on the physicians help to file the claim because of the separation from the complaint system. This is from a patient's point of view. From a physician's point of view, there are almost the same benefits – he can help the patient to compensation, and that is actually what most physicians like to do, without any risk of being met with a sanction in the disciplinary system.

And a well-compensated patient is not likely to file a complaint on the doctor. That is another great advantage for the doctors, and that is why the doctors really like the system in Denmark. The number of complaints to our Complaints Board is declining actually and has been almost since this system was put into force.

And at last, the physicians can concentrate on what they are educated for and what they are good at to cure the patients and not to spend their time in courtrooms trying to prove their innocence. From the public point of view, know how is now collected in our system and it is used in the prevention process. We have done like they do in Sweden. We have coded all of the cases. We have coded 30,000 cases now in accordance with the WHO coding system and in accordance with a NOMESCO system – it's a special Nordic coding system.

So what we have a code for is the patient's underlying disease, the treatment he is undergoing, the injury that took place, and the treatment of the injury. So we can very

easily find patterns in a big number of cases. And when we find patterns in the cases we examine we write articles in medical journals or we make a notice to the healthcare ministry so they can take action.

And from a public point of view, it's a low-cost administration system; it's a system where you can administrate a lot of cases on a very low cost compared to the court system.

Unfortunately there are a few weaknesses in the system too. The durability criterion is very hard for the patients to understand. And some patients get very angry when their claim is declined, because what we have to tell them is that this injury that they are suffering from now - this treatment-related injury - is not very severe, at least not compared to their underlying disease, and that is very hard for them to understand.

A system like this doesn't handle frustrations. Some of the patients are very frustrated and very angry at the doctor, and a system like this does not help with this frustration like a tort-law system do, but they can still complain to our complaints board if they want the doctor to have a disciplinary sanction.

And court cases are not entirely avoided. As I told you, one of the reasons why we introduced the system was to avoid court cases. But the patient can still go to court. He can appeal our appeals board decision to the court – starting in the high court, and furthermore he can appeal from a high court to the Supreme Court. He actually has the right to do that.

Only a few patients does every year, but we have every year about 40 decisions from the high court, and five decisions – somewhere about five decisions from the supreme court – the big majority in favor of the Patient Insurance Appeals Board because the parties in the court case is neither the doctor nor the hospital or the country. The parties in a court case in Denmark will be the patient or the county on the one side, and the Appeals Board on the other side. That makes a great difference your system.

The main question is "Is this system applicable to all of the countries? That may have your interest. I think what it is important that you in some way can separate the issue of compensation from the issue of complaints. That is important in Denmark because if this is not done, you will only have a very few cases in your administrative system.

Furthermore, the amount of compensation – it is a very good idea if it is at the exact same level as in the court system like we have in Denmark. I am not sure you can do that in the U.S., but then you can then make a kind of a fast-track system, maybe even a free system for the patient that can compare to your court system. But in Denmark we have exactly the same amount of compensation. That means that the patient have absolutely no interest in choosing to go to the court. Now with this compulsory system he cannot go to the court.

And you need some kind of cap on the compensation. It's basically for the non-economical losses because a system like this – in Denmark we have 25 times as many claims as we had before this was put into force, and it will be extremely costly if there is no cap on the non-economical losses.

My conclusion is that it is a great system we have in Denmark; it's a great system in Sweden. I hope you will have a compensation system like this, even in a small scale. More patients are compensated. It maintains a good relationship between doctors and patients, patients are given great security when they come to the hospital when they undergo a surgery, and the focus is moved from blame to compensation – that is essential. And it is from the public's point of view a low-cost solution.

So we considered it as a big step forward for all parties, not only for the patients but also for the physicians. It is kind of a win-win situation. Thank you.

(Applause.)

MR.BARRINGER: I think we have time for just a few questions for Martin and Carl.

Q: Could either of you or both of you address the question of the so-called mental injuries and also what kind of psychosocial supports, in addition to encouraging the doctor to work with the injured patient could be provided under this system? Social workers, patient advocates or other kinds of supports for people who are injured? Is that part of your system at all? And can you relate that to the question of – which is a separate question about do you compensate so-called mental or psychological injuries where there is no, quote, physical injuries in evidence?

MR. ERICHSEN: Yes – the first question – yes, we compensate mental injuries too, whereas –

Q: Could you give an example?

MR. ERICHSEN: It is hard to give an example, but, yes, if you have a patient undergoing an anesthesia procedure, some of the patients are not having enough anesthesia, so they wake up during the surgery and they are – some of them are suffering from a mental illness after that. They have no physical illness, but they have a mental illness and we can compensate that. And the other part of your question was –

Q: Psychological or social supports for people going through the process of filing a claim, other than just the doctor himself or the nurse practitioner?

MR. ERICHSEN: But this kind of support seems to be free in Denmark.

Q: (Inaudible, cross talk.)

MR. ERICHSEN: It is part of our social security system so we don't have expenses on that. Yes.

Q: Where do the – I'm not sure I understand where the patients who have, for example, birth injuries not related to malpractices – for example, some forms of cerebral palsy. Where do they fit in the compensation system?

MR. ERICHSEN: Some kind of severe?

Q: Cerebral palsy.

MR. ESPERSON: Well, I think that we have quite many birth-related injuries in Sweden, where we can find no negligence, but with hindsight, when we know all of the facts afterwards, the best physician could have done things in a different way. That is still not negligence, but this is a little bit difficult to explain but –

Q: They are tough cases in – (off mike) – as well – there are tough cases there as well – that they have their gray areas and drawing the line.

MR. ERICHSEN: Of course the causation is one of the problems. Whether this is a treatment related injury or not. But if the injury is treatment-related, in most cases we can compensate it.

This gentleman.

Q: We all know that President Clinton had a coronary bypass in a fine institution by fine doctors, yet he had a complication, which was rare – less than 1 percent, was serious because he had to have another operation. I wonder if in Sweden or Denmark would he have been compensated. The next question is would he have had to file claim, and if so why? Why not have the hospital report it, and the patient then just get a check from the administration since clearly there was an injury that was compensable.

MR. ERICHSEN: He would never have any compensation in Denmark! - He was operated in the U.S. (Laughter, applause.)

MR. BARRINGER: I think we have time for one more question here.

MR. ERICHSEN: That was a joke – no, we can compensate these cases because bypass surgery nowadays is considered as a routine operation more or less. So if it is a severe and rare complication – yes, he can be compensated, at least in the Danish system.

Q: Would he have to file a claim?

MR. ERICHSEN: Yes of course he will have to file a claim, but often what we see in 25 percent or more of the claims, the claim is actually filed from the hospital, and he will be

helped – we have this – I think it’s Danish invention – the ombudsman system. We have patient ombudsmen in every county in Denmark helping the patients to file claims

MR. ESPERSSON: And also you have a social worker at the clinic, and they are the main group that helps the patients to make the claim.

MR. BARRINGER: And physicians also help file claims in many cases.

MR. ERICHSEN: Yes, the lady down there.

Q: Yes. One of the things that I have heard about is whether or not you have a data that supports any – (off mike) – physicians of practitioners who order tests or engage in practice in a way to avoid any kind of claim that they have given to you – necessarily in treatment patients at the level that most experts, professionals would do. And if you are cognizant for the general – (audio break, tape change) –

MR.ESPERSSON: (In progress) – A lot of Swedish doctors have gone to America and now it is becoming a problem even in Sweden. So I have heard with – according to birth, you have a lot of defensive cesarean sections in America, and that is becoming a problem in Sweden. There is a big debate about that because cesarean section is generally a bigger risk for the mother and the child, I mean, if you do it – if you don’t really have to do it. So it is becoming a problem in Sweden – defensive medicine.

MR. BARRINGER: : We are going to try to keep on schedule. We have coffee in the hall and then we will reconvene here in about 10 minutes.

(Applause.)

(Break.)

MR. BARRINGER: Again, we are now going to hear a presentation from George Deebo and Kenney Shipley at the Virginia and Florida Birth-Related Neurological Injury Compensation programs. Without further ado, I will turn it over to them. Thank you.

GEORGE DEEBO: Well, it is good to see a few folks came back. Thanks for letting us be here.

KENNEY SHIPLEY: We are going to share the podium.

MR. DEEBO: Yeah, we have never done this tag team before. We have been phone calls together and we have discussed things but we have never done it together. So we’re going to – this is kind of new for us.

MS. SHIPLEY: Use the mike.

MR. DEEBO: Okay. Can you hear me now?

MS. SHIPLEY: We really have to tag team.

MR. DEEBO: We're are going to be right in front of it I guess, or we can sit down if we need to. Like I said, we have not done this together so we are still working out some of the mechanics, but we also want to say if you have questions during the presentation, feel free to raise your hand and we will go ahead and try to take them. So we would just like to conduct it that way.

As we get started, what I need to ask you to do first of all is think back for a minute. Think back to 1987 and 1988. I can see you starting to do that right now. What was going on in those two years for you? Okay, now, we have news – (scattered laughter) – here are some of the things that were going on around the country.

You had – since I can't see that I will have to use my own notes. In the news – Iran-Contra Affair is a little affair going on with the president – sounds familiar – Russia withdrawal from Afghanistan – you can switch some names out there. Top grossing movies – remember those – maybe go home; you can rent them tonight. Topping the billboard charts – there are your top songs for those two years. We wanted to put you in place of where things got started for us – just thinking, what does that have to do with the topic? Well, we will tell you right now.

But in Florida and Virginia, we were seeing some problems emerge. Many of the OBs were losing insurance coverage, thousands of patients faced no provider coverage in the state. I know in Virginia there were estimates of up to 25 to 30 percent of patients might not have had access to an OB. Malpractice insurers were basically – because malpractice insurers were leaving the state or stop writing policies – and of course the rates were drastically increasing with no associated lawsuits in many cases. There was nothing – you know, a doctor would get rates increased but had no – had not had any claims against him or her that were causing it.

So in 1987 the Birth Injury Act was passed in Virginia and a similar act was passed the following year in Florida.

MS. SHIPLEY: Okay, these were both developed in response to a malpractice insurance crisis, and both of them developed using a no-fault approach – and I think these are truly no-fault approaches – to a very specific medical issue. And I think most of you are familiar with the birth-related issue. Both programs use an administrative court for admission. Both programs provide an appeal process, so a lot of the elements that you see in these two programs are very similar to what has already been discussed earlier with the other plans, the Swedish and Denmark, and what is being proposed by the researchers.

The interesting things – and I think maybe – I think George would agree with me that one of the weaknesses in this approach is that they – in both states are voluntary to some degree. In Virginia they are voluntary for both the hospitals and physicians to

participate, and in Florida the physicians can – have to volunteer to be part of the program; they don't have to participate. Therefore, not every birth is eligible for this compensation.

You are missing your step.

MR. DEEBO: Sorry about that.

MS. SHIPLEY: The good thing about them: They are generally supported by the medical community, generally tolerated and I think very – that is a good way to describe it – tolerated by the legal community – watched very closely of course by the trial bar. The benefits are administered by an independent organization in both cases and the claimants receive what is considered increased benefits over what they would receive because more claims are being compensated – as was raised in terms of Sweden and Denmark, more claims are compensated than otherwise would be.

And both programs are funded by the key stakeholders. Both Florida – can you remember – oh, you want to trade with you?

MR. DEEBO: See, we are still working this one out. We will figure it out. (Audio break.) And –

MS. SHIPLEY: Keep going?

MR. DEEBO: There we go.

One of the things to remember about this program is that it takes a very narrow slice of the whole issue. It is only for these birth injuries. It is not intended to be a general program for a lot of different problems. And that is one thing that in talking to people about the program, they often sort of misunderstand. It has got to be something that occurs basically in the process, in the birth process. So in Virginia – and we'll get to the numbers later, but there is only a few births per year – same as in Florida – that would qualify for this.

One of the other things that is important as you read that, this covers some of the areas – it talks about outliers and uninsurable injuries. Because it's sort of a no-fault system – and we will talk about that more later as well – it covers a lot of situations that would not be covered under the tort system. There are things that in many cases would be difficult to get compensation for that might be covered, and it also doesn't have any limits on how much can be spent on the child afterwards.

So if someone may get a settlement of, say, 100,000, 200,000, 500,000 from a court settlement – we don't have any limits like that on the benefits they can receive as long as the benefits fall under what we allow.

MS. SHIPLEY: Before – and we are going to tag team a little bit. Before I go onto the next slide, I wanted to point out, when George is talking about outliers and uninsurable injuries, back when these two laws were passed, \$10-million verdicts were outliers, and they were considered uninsurable in terms of insurance. And those were the kinds of injuries that were intended to be covered.

We have had two recent verdicts in birth-related cases, one with a non-participating physician, and one in a case that we had accepted, but the judge ruled it wasn't a compensable case because in all of our cases it's mental and physical. And this one it was – he said that she was not mentally damaged. She was only physically damaged. And in the case of the non-participating, the jury verdict was \$63 million. In the case of the physical-only injures, no mental, the jury verdict was \$24 million. And I would represent to you those are uninsurable events. How does an insurance company, how does a hospital, how does anyone plan for that kind of an event?

So we go onto the next slide we were talking about. And this is a statistics just to, again, talk about the number of injuries and the fact that birth-related injuries are one of the things that should be considered for coverage under this kind of a system because they are so common and – well, they are not common in relation to births – they are very few in terms of births, but they are common in terms of claims. They pop out when you look at the claim situation.

And this is PIAA. So these are insured events; these are not the ones – and a lot of doctors in Florida in particular don't carry insurance; they go bear – these are high-impact claims. So they work out – it makes sense to do something other than tort for these systems; it's a much more efficient approach.

MR. DEEBO: Okay. Now I want to talk a little bit about eligibility. This may be where some of you want to hear about. Let me tell you, we decided to combine our presentation because we didn't want to tell you the same thing twice for the most parts of what we are talking about. There are some differences and we are going to try to point those out – I hope it doesn't get confusing – but by and large, things are fairly similar. As I said, the act was passed in Virginia and then the one in Florida was – the language used was very similar in many ways.

The initial claims, they all got to an administrative court as opposed to a county court, circuit court, or whatever you may have. In Florida, that is the Division of Administrative Hearings; in Virginia, it's the Workers' Compensation Commission. Some people have asked me why do they put it there? The best understanding I have is that seemed to be the most logical place. The deputies, the commissioners have some experience in the medical field, as to Florida where you already have – where you have an actual medical –

MS. SHIPLEY: Well, and then Florida originally – we had instructed the same way. In Florida, originally of the claims went to the Division of Workers' Compensation for handling by those judges. We found that those judges really didn't understand birth

injuries intended to let sympathy enter into their deliberations, and the – it wasn't working very well for us at all. So that responsibility was transferred to the Division of Administrative Hearings.

And we essentially have one judge who hears all of the NICA cases. He has been hearing the cases for now – it was transferred I believe in '90. So he has heard every case since 1990. So he has tremendous expertise in NICA cases, and it makes it a lot more predictable to know what kinds of cases he is going to accept, and what kinds of things he is going to key on to say it's not an acceptable case. So that administrative process from our perspective is very efficient.

MR. DEEBO: Well said about workers compensation. It is – for us, we find it sometimes unpredictable as well. In Virginia they rotate – they now rotate the cases by geographic region. Whatever region the petition is filed in, that is the office it goes to, and there will be a different person handling it in most cases for that region. So you get kind of different views as you go around the state.

One of the next steps is medical records are reviewed. In Florida Kenney has some staff nurses and they have two outside experts that review the cases and make a recommendation. And in Virginia, the way ours is set up, we have three state medical schools. Rotating between the medical schools, the cases are sent to each one and they put together a panel of three physicians who review it and then make a recommendation back to workers compensation.

Do you want to add anything about yours?

MS. SHIPLEY: Again, we have a neonatologist that looks at the cases, and we look at it as they are two threshold issues. Number one, did an event occur? And that is the neonatologist looks at did an event occur and he comments on was there an obstetric event. And we had a pediatric neurologist who examines the child, and then determines is there an injury that would be compensable – meets the criteria that is required in the law. So we look at two threshold issues and say here are our experts that then opine on those two issues. That is after they have been reviewed – generally we – our nurses on staff review and we come to a general idea, but we wait to actually file with the judge until we have received the reports from the two experts.

MR. DEEBO: One of the things we have found in Virginia over the years that is changing a little bit is where – at least we believe it was meant to be more of an administrative process, and you take the recommendation of the panel. We still get the panel but sometimes the panels aren't weighed as heavily now as they might have been in year's past. That is sort of my own opinion. We see claimant's attorneys bringing in more specialists from their side. We also have someone else review it from our side. So we have gotten in a situation a little bit where it maybe resembles a tort system at times – not always, but at times it does. We are actually talking about just from the program perspective of how maybe the legislation could be tweaked to put a little more weight back on the medical panels where we kind of think it should be.

And then a decision is made by the judge or the deputy in our case. In Virginia, if you are admitted into the program, there is no tort alternative. So therefore, we sometimes get people who want in the program and sometimes you get people who don't want to go in the program. But if it looks like they may qualify, it has to go to Workers' Comp for a decision. And then in Florida – well, let me let Kenney explain this one a little bit better than I can.

MS. SHIPLEY: Well, if they are admitted into the program they don't have a tort remedy in Florida either. And we have the same – we litigate more cases that they are trying to get out of the program than into the program. So that is a little bit difficult. I wanted to comment too, just in terms of – I'm going back for just a minute. I was – in terms of the administrative law judge, of all of our cases, only five have been decided against what was recommended by our experts. So that is a pretty substantial support for the opinions that are being rendered by our experts, and the positions that have been taken by NICA.

They don't have a tort alternative. We have had – we did have an issue earlier that the – with the claimants trying to settle a case with the hospital or doctor and get NICA in addition. And we had some wording in the statute that made it unclear. And we did have one case that we ended up doing both, but that was resolved with legislation in 1998. So now there really is no alternative if they are admitted to the program.

MR. DEEBO: And interestingly, in case you are wondering, in Virginia at least, we have had the legislation modified at least four or five times over the years. And I can see that continuing as we go forward. We are talking about some changes this year as well. And I think it's just a process of we are learning more about how things work. And each time we see something that may need to be altered or changed or improved, we are trying to go back in and say, okay, let's look at this and see if we can improve it somehow.

MS. SHIPLEY: And we have had a great time talking together about the – there are a lot of similarities in the program; there are a lot of differences when you get down to the detail level, but both programs have some real good strengths, and there are some things that both of us would like to see improve too.

One of the great things that – most of the time I get questions about this – once they are admitted to the program, they are in the program; there is no alternative. There is a lifetime of care. We have to plan to cover whatever the needs are forever. And one of the things that we are finding is the mortality rates are relatively low when you have the level of care that we provide that goes beyond what either Medicaid or insurance will normally provide under their policies.

So we have – the life expectancies have increased consistently over time for Florida. And I don't know about Virginia, but I know that Florida – that is one of the things that we have seen.

There is no cap on the costs, so whatever it costs we pay. I won't speak for Virginia – I know that we generally use Medicaid guidelines and are able to negotiate reimbursement at Medicaid levels in most cases for most services and most equipment. That isn't always the case because we are providing things that they don't otherwise cover. And the only limitation is medically necessary. And our statutory scheme, the medically necessary really isn't defined, so it ends up being defined by case law and it's a fairly broad standard.

MR. DEEBO: We are pretty much in the same place. Oh, there we have it; we already have it.

MS. SHIPLEY: We got it, okay. Sorry. It is a very efficient system. If you look at this kind of system compared to the tort system – what always kills me is you look at those big verdicts like the \$24 million and the \$63 million, and 40 percent of that is going to the attorney. Now, I'm sure that those are settled at less than what the actual verdict was. They don't really go for that kind of money, but it's enough to say those are big-dollar cases, and 40 percent of those dollars are going to a lawyer, which is of course a great incentive for the trial bar to not to want to support this kind of a plan.

But if you look at – Florida's numbers are a little – I have expressed our numbers on an incurred basis because it is comparable to the verdict. On an incurred basis over time – the lifetime of the claim, what we are paying in attorneys' fees amounts to about 2.3 percent. And Virginia is reporting their numbers on a paid basis at what I think is outstanding – 4 percent. On a paid basis, we actually pay about – to date we have paid about 7 percent. That has gone down over time. It was 9 percent earlier. It has gone down because over time of course hopefully attorneys' fees represent less on a paid basis as the program ages. But it is still, compared to the tort system, is a very efficient system.

Most of our cases are settled, handled, accepted, and payments begin within the six months. And we really don't look at fault; it's not even an issue in our determination in the eligibility. It's not even something that we – we don't look at it. So I think this is – even in terms of how we cover, I don't think it's part of the scheme.

MR. DEEBO: I will comment on that also, though, that in Virginia at least, our attorneys' fees are going up a little bit partially just because we have more petitions coming, partially because the claimant attorneys are starting to file higher fees, or ask for higher fees, and that becomes another issue we have to deal with. I think traditionally as I look back – I have been with the program about three years – I look back at the fees we have paid for a child to come in, say, at the first level of the hearing. Most fees were often less than 5,000, sometimes 10,000, and occasionally crept up a little above that.

We now have a couple of folks, attorneys, who are routinely submitting fees for the same level of work at the 20, 30, 40,000 level. And so we go back and say, okay, let's try to take a look, though, to see why it is happening. They have their reasons, we

make our reasons, we see where it comes out. So we do see that escalating a little bit and that is an issue we are trying to deal with.

Funding – here is the fun part. In both states, physicians and midwives can voluntarily participate in the system. Florida, for physicians, is \$5,000 a year, and I think 2,500 for midwives. Is that what it is? In Virginia it had been 5,000 for physicians and midwives for many, many years, until about two years ago we had the statute changed, and now it's starting to creep up just a little bit. It will – it goes up \$200 per year until we hit 5,500. So it is not a huge increase; it's a very small one.

Hospitals – in Florida, it is mandatory participation; in Virginia it is voluntary – \$50 per live birth in the prior year, and in Virginia we have a maximum of what a hospital will pay in. It was 150 as part of the same statute I mentioned before. It is creeping up, and it will go up to 200,000, max. But, again, it is voluntary.

Anything you want to add about the mandatory participation in hospitals? Okay, we also have I think in both states – I'm going to let Kenney talk to hers a little bit; let me talk to Virginia – two other revenue streams. One is a mandatory physician fee. All physicians who are licensed and actually practicing in Virginia must pay into the program – it was \$250 a year; it's now gone up to \$270 – that one is increasing as well – up to 300.

This is a stream that by law is only used when we are actually unsound, which is where we are at right now in Virginia. So it has been in use for about three or four years, and I think it went back into use – as well as an assessment of Virginia liability insurers – one-quarter of 1 percent – it is one-quarter of 1 percent of annual premiums they pay to the program. And, again, that is another one that is only used if we are considered actuarially unsound.

Do you want to speak to yours?

MS. SHIPLEY: And Florida has the same provision. We have not had to exercise that provision fortunately but we also have done a couple of things that I think are unique. We have been reinsured. We at this point cannot purchase reinsurance, but up until 2004, we carried reinsurance, both specific and aggregate, and that has contributed to the financial soundness of the plan. We also have investment strategies that I think are intended to address the lifetime care of the children.

So those I think are important things to consider when you get into this kind of a program because typically legislatures look at cash-flow funding on a year-to-year basis, and they don't understand how that escalates over time. And the reason that we have been able to maintain our stability is because we have consistently gone to the legislature with our actuaries saying this is what it takes to fund lifetime care when you are looking at life expectancies increasing over time. You have to anticipate that those costs are going to be there. So that is important.

MR. DEEBO: I will just say in Virginia we have not had any general funds revenue put into the program directly. We do get some services obviously from Workers' Comp, and from other agencies that provide some support services, but we have no direct funds. I think you all had a little bit in the beginning.

MS. SHIPLEY: We had 20 million in the beginning.

MR. DEEBO: All right.

MS. SHIPLEY: So, yes, we did have – 20 million was contributed from what was in the insurance regulatory trust fund, so that basically was money that came in from insurers, and that 20 million is available if we are ever in any kind of problem as well.

In Florida we have accepted over 200 cases. We generally accepted about 35 percent of the claims. That seems like a small number. The majority of the ones that we don't accept is because it's – we have a different restriction than Virginia does. We have a birth-weight limitation, and we – a lot of claims come in that don't meet the birthrate, non-participating physician, the injury doesn't meet the threshold, it's not as – it has to be mental and physical – substantial, and a lot of times that is the reason for the claims not being accepted.

We have actually 98 currently receiving services and the majority of our expense is nursing care. I think Virginia – George will tell you that in Virginia we find similar things because we pay after Medicaid or insurance, the majority of our expenses are going to be in things like therapies that wouldn't – where there are limitations or caps, nursing care. Medicaid and insurers typically either don't pay or limit the private-duty nursing and we are not able to do that – and durable medical equipment, and therapy. So those are our biggest ones right now.

MR. DEEBO: Virginia's situation looks a lot alike. We have fewer cases accepted at this point. And I am not sure why that is exactly in terms – well, there could be a lot of different reasons. We may not – in the early years the program – there were concerns about people knowing about it; there wasn't a very clear requirement of informing patients – that has been changed. So now there is some mandatory requirements for informing patients.

We have about 88 – I think that has gone up one or two – currently receiving services and benefits. Of course – unfortunately you have a couple – one or two a year who die so that your numbers sort of kind of go up and down a little bit.

The majority of expense, as Kenney said, really is nursing care. There are children who have everything from no nursing care because there families just don't want any to some that have 24-hour care in the home. So it really spans that whole – it is a whole span of events there. And, as you would expect, when you have 24-hour nursing, it gets very expensive very, very quickly, assuming you can find nurses to staff that. That

has been another issue we have had, and a real challenge in some areas, especially Northern Virginia – it's been one of our toughest areas to find available nurses for folks.

MS. SHIPLEY: George was talking – we were talking about this and George was saying one or two deaths a year. We haven't had a year since 2003. Now, prior to 2003, there were five deaths in, like, a four-month period, but we haven't had a – we haven't lost one since then.

I should clarify the numbers too so you can see where some of the difference is. If a child has applied – was born alive but has passed since, we assume that from an injury standpoint that the injury – if there was an OB event that qualifies, we assume that the injury meets that test because we already have a limitation in place that addresses premature problems. So a lot of the cases that we have – have come in and we have paid a death benefit, and that is all we have paid. So a lot of our cases you will see we have only 98 that are actively – but we have accepted a lot of cases where the child was born alive but passed shortly after.

MR. DEEBO: I would also just mention, we do see a lot of I think pretty good screening by the attorneys that work with claimants. They tend to do a pretty good job, and ones that we are familiar with in determining whether they might be eligible or not. So some of that – I think there is some pre-screening that goes on there.

MS. SHIPLEY: When we talk about benefits, nursing care is our biggest costs. It is one of the things – as I said before – is generally not covered or limited in coverage by Medicaid and/or insurance. So nursing care is one of our biggest costs. And of course we pay after Medicaid and/or any other insurance. George and I were talking about the meeting about housing and transportation costs because those are things that generally are not insured, and we both pay fairly substantial amounts because both of our laws say you will pay – I pay for handicap modifications, and I pay for handicap-equipped vans for the families and the limitations on those are very hard to control. And George can tell you –

MR. DEEBO: Yeah, we also pay a transportation – we provide – when a child needs – is in a wheelchair fulltime, we provide a van to transport them, a wheelchair-equipped van. Housing is a little bit interesting. In Virginia, it's had a tumultuous history of what has been provided for – in the earlier years – it was interesting, in the early years of the program, it was very slow with kids coming in; there weren't a lot in the first few years, so all of this money was accumulating and people were like, what are you doing with this money that is coming in there?

Well, one of the things they decided to do, even though it's not required, was provide some housing benefits. And that has ranged from providing a home for them to live in, grants to build a home that is handicapped accessible. Well, where it stands now is in Virginia we provide – we will build a bedroom and a bath add-on to the family home and make some other modifications. And as you can imagine, the cost of that ranges all around the state anywhere – it might be – in some parts of the state you might be able to do it for 25 (thousand dollars), \$30,000. If you go across the river here, you are pushing

the outer limits of our allowance of \$175,000 in some cases. So that is where we stand on the housing.

MS. SHIPLEY: And I choked when I heard that number because we don't do that.

The big problem that we have in problem is, along with it being a voluntary system, the physician and doctor – I'm sorry, physician and hospital and required to give notice to the patient that they participate in this program. There is a brochure that we prepare, we print, and provide to all of the physicians and hospitals. They have to hand it out, and they have to be able to prove that they gave that to the patient, and that has been an issue that has been litigated, and that is the way that a lot of the petitioners have tried to get out of the system by saying that either the doctor or the hospital had failed to provide that brochure.

We litigated early on the sufficiency of the brochure as noticed so it has been held to be sufficient. We have provided guidelines for what is acceptable to provide as evidence of having given that, but it continues to be a very heavily litigated issue, and one that allows a number of patients and a number of people to escape from the system. So it is something that we would look at closely in any – as you're designing a system, that is one of the things that you need to be careful about.

We do have – a couple of years ago, we had some issues raised by families that when the children – when the child does pass, at that point the child has been uninsurable most of the time, and the families don't carry life insurance, have not been able to get life insurance to cover the cost of burial. And so one of the things that we added to our benefits was a \$10,000 death benefit in order to allow coverage for those – that when the child passes.

MR. DEEBO: Virginia issues – our biggest issue, as I was talking to a couple of folks earlier is really about the definition of what the injury consists of. That is something that the – not being a clinical person – a clinician myself – I won't go into it too deeply, but what exactly is a birth injury under the statute and when does a child meet that definition? That has been something that has sort of been a topic of discussion and debate to a large – very much both in the cases and outside of the cases. So that is something that is ongoing.

And a big part of that nowadays is the issue of prematurity. We do not have a weight limit or a gestational age limit or anything like that. And the issue of what is caused by the prematurity and what is caused by some other event. And it can be a very fine line about which is which, and so that is something we are really struggling with, we are looking at different language for legislation possibly, or how it needs to be changed, or whatever, but that is one of the key things we are looking at at this point.

Funding for us – I would love to be in their position financially. I am trying to make a trade for some other benefits or something earlier. I couldn't get anywhere – any

future draft choices for funds or anything like that. But we do – we do have a deficit, which is at about 100 million right now. If you look at it from the actuarial standpoint, part of what they look at is not just the kids who are in the program, but they say there is a number of kids waiting out there to come in. They may or may not come in. So at least from the time I have been around the program, most of them haven't come in. So you sort of question from an actuarial standpoint how accurate it is. And being that the programs are only 20 years old at most, it is a tough thing for them to know exactly what is accurate and what is not.

MS. SHIPLEY: The actuaries are never accurate. What you have to ask is are they too high or too low. And they all tell me that; it's true. Do you want a high guess or do you want a low guess?

MR. DEEBO: You can guess our answers. But one of the things we are doing to address that is we are in the midst of a funding study right now to see what kinds of steps we could take to stem that – the deficit. The good thing is when we look at it, the funds that we have in reserve now – about 145 million – appear to be in pretty good shape at covering all of the kids who are in the program at this point. So that is one good point.

Let's see, what else – scope of benefits – I think that is something that continues to evolve probably for both of us. We were talking about experimental therapies before we came up here today. How do you deal with experimental therapies? When you should pay for them? When shouldn't you pay for them? That is certainly an issue. And then as I have mentioned earlier, the escalating claims and attorneys fees.

MS. SHIPLEY: And I was going to – on the attorneys fees, we have been very fortunate. We litigated early on the attorney-fee issue, and we pay \$150 an hour. And, again, we have the administrative law judge who determines that, and he has been very consistent that that is what we pay, so that we have been very fortunate in.

I really appreciate the opportunity to be here and hear all of the different viewpoints. And, Paul, thank you for inviting us because I think it's a wonderful forum. And is there any questions?

MR. DEEBO: Where do you want to start?

MS. SHIPLEY: Go ahead.

Q: Hi. I was wondering if there are any political implications for – (inaudible) – program. I know that Virginia is having an election this weekend. What are the political implications that you have seen in dealing with this program since it started up to the present?

MR. BARRINGER: The question is about the political implications of the program from inception to the present.

MS. SHIPLEY: How long do we have? (Laughter.)

MR. DEEBO: Yeah. Do you want to start? I would just say – I mean, one of the things I have learned in the last three years, if I – if we are doing a legislative visit, you usually have to look under the desk for the legislator because they just don't want to deal with it to a large degree. I mean, they are somewhat very, very concerned, but it's such a complex issue; it has so many emotions involved – I mean, you see the photos of the kids, a couple of the kids in the Virginia program. I mean, wonderful kids, but it's just – the whole thing is filled with emotion. It is very difficult to deal with in some ways.

We have gone in the last couple of years and talked about adding a weight – birth-weight limit like Florida has into ours. And we have come very, very close to getting it in, but there is always enough folks that say, well, I just don't want to go down that road. I don't want to tell anyone that they might not be eligible for the program even though it is not a program for premature kids; it's a program for birth-injured kids. So that has certainly been an issue. Like I said, we have had a lot of legislation go through so obviously many have been willing to deal with it.

MS. SHIPLEY: We have been pretty fortunate. We have been studied so often, and the results have been that at least it's an efficient program, even if it doesn't answer all of the questions and solve all of the problems. And our legislature has been relatively supportive. I will say my general counsel has worked very hard with the attorneys around the state and with the plaintiff bar to develop at least a healthy respect for each other. So I can't say that we don't have our uphill battles, but we have worked out a lot of the problems and have had a good deal of support partly because we have had favorable reports when being reviewed along with other malpractice issues. It has been an efficient system; we have done what we needed to do, so we have gotten fairly good support.

MR. DEEBO: And I would just also add, I mean, one of the good things is in the studies that have been done, there does seem to be a positive impact. So that is often something we can go and talk to people about. Yes, sir.

Q: What percentage of children with cerebral palsy in your state are covered under your – (off mike) – because your original definition was so restricted that you had to be permanently and unalterably, mentally, et cetera, et cetera, et cetera.

MR. BARRINGER: The question for those in the back of the room is what percentage of children with cerebral palsy are covered by the programs in the state?

MR. DEEBO: I don't know. I am sure it's a very small amount certainly.

MS. SHIPLEY: Well, let's say that there is not a disqualifier. The question is what is their physical condition? And both laws require both mental and physical impairment. If the CP involves them to a degree that there is both a mental and physical impairment, they can be covered. There is not – I don't know about George. I know that

I have never used ACOG's to say it's not a birth-related injury. I have read it and I think it's good research, but I certainly wouldn't try to say it's one of the cases that shouldn't be covered just because it's CP.

Q: The Virginia one stated it had to be due to oxygen deprivation, and only people who are permanently non-ambulatory, aphasic, and in need of assistance (in all activities ?) of daily living were eligible. Has that changed?

MR. DEEBO: Yeah, that is not quite the definition. See, this is why I bring my lawyer with me right over here. (Laughter.) It has changed. It basically reads something to the effect of needs assistance in all activities of daily life, is roughly where that part of it goes. Carla, do you –

CARLA: I can read the definition if you would like.

MR. DEEBO: Would you like her to read the definition?

Q: No. (Laughter.)

CARLA: So he doesn't want the answer. (Chuckles.)

Q: I have kind of – it might be considered a thick question, but I'm going to ask it anyway. Let's pretend -- and I am no policymaker -- but let's pretend that I am a woman who has had a bad outcomes at birth regardless of whether it's related to negligence. I will be in Florida. I am in Florida. I have a child that regardless of whether it's negligence or not requires a lifetime worth of care – physical, mental, whatever.

What would motivate me, if I have sent the case – let's say I talked to a plaintiff's attorney. The plaintiff – he has some experts that are saying, you know what, a lot of errors were made here and I believe you have a sound case of malpractice against both the physician or midwife, and the hospital. And I know in Florida many of the physicians do go bear – so the hospital, the nursing staff.

Given that you have just presented information that there were judgments of \$23 million, \$64 million, what is the motivating factor for me looking at that – because I'm sure they made the news – to opt in to the voluntary compensation program versus roll the dice if the plaintiff's attorney tells me I have a good chance and hit the jackpot so that not only will my child be well taken care of, our lifestyle will be, well, I never have to worry again. I am just trying to figure out how I as a public person with maybe a limited education get motivated to opt into the compensation program versus take my chances with scoring a huge judgment. And not – with the basic case that I want help for my child.

MS. SHIPLEY: You have got a couple of things. First of all, your chances of scoring that case are relatively low. You have got a – and he is going to have to take that into consideration in looking at his own malpractice insurance. And we have – well, I

won't go into those cases, but we have had situations where it should have been a NICA-covered maybe; it wasn't, and they ended up not having coverage anywhere. That is one thing.

If in Florida everybody is given the notice, and you have got participating physicians, you don't have a choice; you're in the system. But we also have people that want in the system because there is care forever, there is no cap; it's whatever your child needs that is medically necessary. We provide the handicap-accessible – I don't do quite what George does, but we do modifications for handicap-accessible. We provide the wheelchair vans and we are there – we provide all kinds of support that I don't think either one of us could go into the level of support.

I visit the families. I'm not sure that you want to do that in a general malpractice system. But I visit the families. We provide all kinds of interaction through our nurses with the providers. We find care for them. So there are a lot of things that aren't in our necessarily what we publish, and aren't in the statistics, and aren't in the kinds of things that you are really considering for this system that go along with – especially when you are dealing with birth-related injuries, it's that coordination, it's that personal touch, it's the nurse they can call 10 times a day – and we have people that call us 10 times a day just to talk.

So there are a lot of things that we provide that I can't really put a price tag on, but they are reasons that you might want to consider being part of that system.

MR. BARRINGER: Thank you all very much for those presentations. Now, we're going to move to the panel session and Troy Brennan will moderate this session. I would like to invite David Swankin, Steve Sleigh, Jackson Williams, and Martie Hatlie to come forward for this session. Thanks.

(Pause.)

TROYEN BRENNAN: Okay, so we're trying to keep on track here. Everybody wants to leave by 5:00 and wants to hear as much as possible, both from the audience and from this distinguished group of panelists we have here. So I'm not overly organized here, I thought that a way to proceed would be to ask each of the panelists to give us, sort of three to five minutes of reaction to what they've heard so far. Jackson Williams is here from the American Association of Retired Persons. And then next to him is David Swankin who is representing the Citizen Advocacy Center, where he is the CEO, and then Stephen Sleigh from the International Association of Machinists and Aerospace Workers, and then finally on the far right, Martie Hatlie. They all have much more extensive biographies that are in your folders on this red page. I won't go into them in detail now in the interests of time. But go ahead and get started. Jackson, did you want to start?

JACKSON WILLIAMS: Sure, thanks. Is there somebody who could show me how to work this thing, by the way?

MR. WILLIAMS: I just want to move to the other slide. Oh, okay. Left arrow. Well, anyway, thanks Paul. AARP supports the concept of a publicly sanctioned demonstration project to test administrative compensation. We have some concerns about the nitty-gritty of the project design, and that is actually what – I brought in two slides to show you that I think sort of demonstrate how, when you're representing retired folks primarily or people who are at the end of their working careers, why you would be concerned about the particulars of a damage schedule. And, of course, as the Harvard team indicated, and I think as Dr. Studdert had indicated in one of his earlier law review articles on this, I think the lions share of the scheduled damages under – I keep wanting to say no-fault, which is the shorthand that a lot of people in the policy community use, which I understand is a no-no – but an administrative system, what exactly does it mean in terms of the damages that folks get?

And if you look at this slide, this is very interesting. This is from the Consumer Products Safety Commission. It's a little bit out of date in terms of the dollar amounts, but it's really the scale that I wanted to talk about today. And what you see on this slide is up to age 55, your wage loss damages are at least four times what they are after age 65. So what you see is that once you've hit the traditional retirement age, your prospective damages are a lot smaller than they are when you're in – not even in your peak working years, but in any of your working years.

Okay, I'm sorry. This other slide, which I hope we'll see in a second, shows the point at which your earnings – your wage earnings – are surpassed by your household production. So in other words, when you're disabled and are no longer able to work outside of the home, you sustain a wage loss, but you also sustain the loss of the household production that you do – mowing the lawn, things of that nature. And for women at about age 55, and for men at about age 75, the household production exceeds wage loss in terms of your damages. So the reason I bring this up is that I know that the Harvard folks in an earlier permutation of this had talked about not including household production damages, so my first point I guess would be that I would hope the schedule would not exclude household production damages.

Last Friday, Paul and some other folks here and I were up at the University of Maryland Law School, and we heard a presentation from Bill Sage who presented findings from his study of Texas medical malpractice claims. And he had some interesting findings, the first one being that the rate of paid claims to elderly claimants is only about a quarter of the rate for other adults of working age. And of course, this is why AARP is interested in this issue. He attributes this to the fact that the wage loss is lower as you get to the end of your life, and it's less economical for an attorney to take that case. So this is something that obviously we would like to see resolved by the idea of an administrative system. The other finding that he had was that the average award to the elderly claimant is somewhat lower than it is to working claimants, but nowhere near the magnitude of 4 to 1. It's maybe about 30 percent lower, so a schedule of damages that relies heavily on lost earnings is actually going to increase the disparity in the award amount to elderly relative to not elderly claimants.

The final item that I wanted to bring up is the role of incentives. As you know, economists love to talk about incentives, and in health care policy, incentives are at the heart of so many debates about how do you align incentives for quality of care, how do you align incentives so that the insurance market works, or for health insurance. And of course, perverse incentives are at the heart of the malpractice debate, perverse incentives to not report errors or to practice defensive medicine. The role of positive incentives is widely dismissed in the malpractice debate, meaning that it's politically incorrect to say that there is any deterrence. But I do think that the issue of deterrence, which is placing the cost burden of errors on the providers who are in the best position to avert the errors is a key component of doing this right. So the important distinction between the Nordic model and the Harvard model, of which I heartily approve, is enterprise liability rather than social insurance – that the provider is going to bear the costs of these injuries.

I just wanted to note that in the past month, I've read a couple of pieces discussing medical liability tangentially to discussions of quality assurance. One was an article by Milton Friedman that was written 50 years ago, and the other one was the Health Affairs piece by Enthoven. Both of them reached the same conclusion about – and that was the piece that was just published a month or so ago. And both of them reached the same conclusion that enterprise liability in the context of an integrated delivery system is the best way to harness incentives for safety on the institutional level. So I think enterprise liability would certainly do that, and I do see an administrative system in an integrated delivery system as possibly a good way to get these incentives harnessed in a positive way.

But the other lurking question is the differential incentives that arise when you schedule damages. When you look at these slides – I don't know – well, I guess the other slide would be a better one to show you, but I have no idea how to get back to it – but what you see even on this curve here is that the stakes are so much higher for a hospital or a provider when they're treating people at peak working age than when you're treating somebody at retirement age. And if you're making some sort of a cost-benefit analysis of whether to implement a particular safety system that the analysis outcome is going to be different for the 25-year old patient than for the 65-year old patient. And because of the way health care is structured – for instance, if you had a multiple facility integrated delivery system, where there are several hospitals, it would be theoretically possible to put patients who are higher stakes in terms of the damage schedule in a hospital that has more safety systems than you would perhaps hospitalize a patient over 65 years old. So I look forward to hearing from the Harvard team why my worries about that are unfounded. Thank you very much.

(Applause.)

TROYEN BRENNAN: David, did you want to make a couple comments?

DAVID SWANKIN: I know you have my bio in your materials, but what I don't think it told you was that many years ago, my first job in the government actually was to

monitor state worker's compensation laws, and to observe the whole process. Later on in my government career, I also was an executive secretary to an association of worker's compensation directors. So a lot of things that I have to say have to do with what I've learned from that system, even though I know that Troy and his colleagues have rejected the notion of pure no-fault. So let me just go on and hope that they're useful.

How many people in this room come from public interest consumer community? And the reason I ask that is that an awful lot of understanding whether individuals or groups support or oppose the concept of specialty courts depends on where people come from. I think that if you look at where we are now with malpractice, it began – I'm not a researcher – but it began, in my view, with a call for tort reform, mostly product liability reform in the '60s and '70s. And then malpractice kind of has taken over and gone into first place, center tent, from the push for product liability reform. But it came from industry. It didn't come from consumers.

If you go back into the history of worker's compensation – I was listening to the presentations from Europe – it was a movement to improve the social safety network. It didn't come from employers. It came because there was a feeling that workers didn't have a shot in court. Assumption of the risk meant you didn't get paid. And so there was an effort to pass worker's compensation laws to deal with that, and so they were beloved by workers and social reformers.

I also was interested to hear the presentations from Scandinavia that the programs are beloved. They're beloved because they're in a country where people think paying 50 percent of their income in taxes is good, because they get back many, many social benefits in return. People are used to that and you didn't have a big sell job, I don't think, in Scandinavia, because it was in the setting of social welfare, which is what the governments there are all about. And that isn't true here, so right away, the point I wanted to make is, there is a lot of suspicion in the consumer community that I know best about any effort to do something about the current system, even if you recognize all the inequities of it.

These same groups – I know I go back a long way – were very, very supportive, of automobile no-fault. A lot of them – where they really got upset was the prostitution of the concept when the state legislatures got a hold of it, because in virtually no state did anybody ever enact legislation that took the ideas that had been developed and implement them, so it got a bad name because it didn't work. But it didn't work in the implementation, not in the concept.

The second point I wanted to make was that I was glad, Troy, when your bottom line on the whole presentation today was where you now are calling for an experiment, rather than say we're ready to do x or y, either nationwide or federally or nationwide at the state. And part of your – and when I say you, I mean your whole team – I think that part of the reason for the experiment as you described it was to examine whether to go for all clinical conditions or should we cherry-pick particular ones where it would be easier to implement the concepts here and there. You have to go slow.

I think you have to go slow for different reasons, and again, it's this gap between the concept and the reality, because if you look what happened in worker's comp, even with the differences of how it came about, there were tremendous – and still are – tremendous problems with the implementation of this idea a hundred years later – more than a hundred years later. I mean look what happened, how slow the system was to cover black lung disease and every other industrial disease, such as silicosis and asbestosis. The state systems lagged for a lot of different reasons. It would be costly to do it, but the concept originally was if you got hurt on the job, you're going to get paid for it. But it didn't work out that way because real problems in implementation. It turned out to make a really big difference depending upon who were making the decisions over whether you proved that the injury was work-related, and whether you proved the percentage of disability, and those go on today.

Moreover, now in a lot of states worker's compensation is in serious financial trouble. And what do you do when it's in financial trouble? The rates go up big or there are efforts to cut back the expenses. I mean that's what anybody responsible that is running a program does, so that even 100 years later in worker's comp, there are gaps between what it looks like as a theory and what happens in practice. I think to try to do this without getting a lot of experience before we're ready to say that it's something that we're ready to buy as a replacement for the current tort system – we're just not there yet.

And the last point is that given where I'm coming from, I really need to see the tie between stopping errors or reducing errors in the first place and making the compensation system fairer, because from my perspective – and I think a lot of consumer groups – what you're looking at is there is a whole spectrum that begins with things going bad. And it ends with taking care of it. And I think that if you ask most citizen groups, they would say we don't do nearly enough on the front end. We're putting a lot of attention into trying to fix up the back end, and that's not to say – you know, when you work on a problem, you have to take a piece of it and address it, so I'm a supporter of the notion. Let's take the compensation system and look at it. But let's tie it back to the safety and error prevention causes.

And my last lesson from compensation is we did not do a good job in relating the front end to the back end, because except for experience rating in worker's comp, we could have done many more things to relate safety oversight to paying for it and we didn't do it. It took until 1970 to pass OSHA. And the reason OSHA passed was because the states were doing a horrible job in overseeing safety. The severity rate and the frequency rates for occupational injuries and illnesses were way too high.

But the worker compensation system never funded the safety regulating system. I think there was one state – there was only one state where a percentage of premium went to fund the state regulatory programs, the state OSHAs, and so you had weak programs, ineffective programs, bad standards, and you never tied the two together. If you got hurt, you got paid for it, but no effort really to relate that system back to safety improvement, except experience rating with large companies. So I think those are our lessons we have

to learn as we apply this, and in ending I would say we do have to experiment with different ways; but that's the key word is experiment, until we know a lot more. Thank you.

(Applause.)

STEPHEN SLEIGH: Thank you, Troy, and thank you, Paul, for inviting us to give some brief remarks. You know, this whole issue of the medical malpractice and looking at alternatives – you have to look at it in the context of our health care system. In the past year, I've been involved in 50 sets of negotiations with small companies, large companies, and at every single bargaining table, health care costs are the number one issue, and the number one issue that would cause work disputes, labor disputes, strikes. We just had a strike at Boeing that went 28 days over retiree health care. And in each one of those bargaining tables, in addition to fighting over the costs – 16 percent of our gross domestic product, twice what it is in Sweden – just a horrendous figure for what we get. Dr. Lucian Leape is in the back. He has documented the failures of our health care system in terms of quality. Someone referenced the IOM studies that came out in the last six years, ranging anywhere from 100,000 lives a year to 150,000 lives a year lost due to preventable medical errors. For a price tag that is causing labor disputes, economic loss twice the average of the OECD countries, we have a very inefficient system.

And the reason we have a very inefficient system is because we don't have a system that is accountable. No one is accountable in our system, and thus the problem of having individual lawsuits that ended up with 24 60 million dollar lawsuits. Let me just make clear that my organization has not endorsed any particular position on this whole question. We're very engaged in the whole approach to having a national solution to the affordability and quality of health care. And I think that this may be a part of that solution as having some sort of administrative approach to medical malpractice. But I think it has to tie back into the key role that consumers – patients will play in the system in the future.

Currently, because of the lack of accountability and information our members are at a complete disadvantage. They have no information upon which to choose one doctor or even a hospital. More and more, hospital level data is getting out there. But to choose an individual doctor whether their quality is good or bad, there is virtually no information.

It was curious to me that this administration that is so against national solutions, their health care guru, David Braylor was on the cover of Business Week the other day saying this man wants to save health care. A fascinating article because the way that Braylor is going to save health care is through information technology, and information technology relies on information. If consumers don't have the basic information about the performance of doctors and hospitals, then there can be no solution. And that's why I think we have to go to a social insurance model, a national model. I'd love to have our friends from Sweden help us figure out how we get there short of everyone moving over to your country. We welcome your input.

But I really do want to put this in context – for working Americans, this is a crisis. This is not an abstract policy issue. This is not something to be experimented around for the next 20 years. Time is running out for American manufacturers. We can't compete with countries that have figured out the solutions to these kinds of problems. And the urgency of coming up with a solution to provide the consumers with accurate information so they can choose well and to contain the cost – that is something that we've got to roll up our sleeves and get to. Thank you.

(Applause.)

MARTIN HATLIE: I too really enjoyed this program and I learned a lot by sitting through all the presentations, some of which I knew a little bit about, but again it was a good refresher and there was much more that I learned. From the very beginning, I was happy to see Mr. Ingram and then most recently David talk about the importance of integrating the patient safety discussion and the medical malpractice reform discussion. I think those are really important. And as Troy mentioned in your comments, they kind spring from the same roots.

And clearly a lot of the modern patient safety movement as we know it really came out of a frustration with medical error and not being able to get tort reform. I was involved in launching the National Patient Safety Foundation from the AMA and we made a conscious effort back in '96-97 to not discuss patient safety and tort reform in the same breath. Adam was there as well. And it was partly because we were afraid that the public would think that we were actually using patient safety as a strategy to get tort reform. I think the issue has really evolved since then and we have to look at these things together. If you think of the sort of classic model from human factors, thinking of the sharp end and the blunt end, the sharp end is where service is delivered, the blunt end is the back of the organization that creates culture and influences what is done at the sharp end. The legal system is part of that blunt end. We're not going to really get good outcomes at the front end unless we have our legal system aligned to encourage patient safety. People have mentioned the joint commission white paper, which is also excellent and we're starting to see these issues integrated, certainly, in state initiatives, so I think that's just a really good trend and a really important thing to keep in mind here.

Also, my background is as a lobbyist so when I heard David and Michelle and Troy present this morning, my first thoughts were really how do you sell this thing, because it's very complex. And I think an emphasis on the patient safety aspects of it, the prevention of errors aspect, a prevention of injuries aspect could be an important part of the sales pitch here. People don't just sue because they want compensation or because they're angry and want justice. They sue because they want change. And we've sold the public a bill of goods that the tort system somehow deters. It really doesn't. So finding a better way to feed patient experiences into some kind of a learning system, I think would be a big step forward. I was struck by Martin's presentation of the Danish system, the piece on reporting, the fact that you have a reporting system that actually feeds back

information that comes through your claim system into quality improvement – I think is the kind of thing that would be really important and would meet some of that public need.

I haven't really organized notes here – I was also struck that in the Danish system and the Swedish system there was some kind of attempt to adjust the benefits or adjust things that might be excluded by the model we're talking about here. So we're talking about excluding claims against managed care. We're talking about excluding claims having to do with medication errors. And I think that's going to be obviously very problematic again in trying to sell this because the people you're excluding are not going to be real happy about that.

I thought that the lesson from I think it was Sweden of creating the sort of parallel medication error system along with the medical malcompensation system was a really nice touch. We should think about that as a way to move forward here. Also, I think in the Danish system, you mentioned that the benefits that you get going to the court system, those that you get going to the compensation system are essentially parallel or similar. That would go a long way to diffusing the kind of things that I think we're going to run into if we try to do pilots where you get a different set of benefits for certain kinds of claims, all that kind of shifting of behavior.

You know, again, on the sort of sales issue, we made a point I think in hearing about the pilot you've designed so far about how hospitals, health care organizations, and liability insurers could be kind of primary organizations to pilot something in the state. But we clearly have to think about the reaction of the primary insurers and the disability insurers who are going to bear some of the cost-shifting aspects of this, that they really are going to be the first dollar paid out. Clearly, that's something that makes the systems in Sweden and Denmark affordable. Up to 80 percent of the costs are paid by primary insurers.

Another constituency that has to be brought into this debate – trial lawyers. I mean really, there was a little bit of talk at the beginning about how there really wouldn't be a role for them at the front end of the system. We didn't go into much detail about where there would ever be a role for them in this system, but it's not something that we're going to be able to ignore as we take this to the American public and ask for their support – the same thing with pharmaceutical companies.

And finally, I know that this is work yet to be done – this is still a work in process – but the constitutionality issues are another kind of really thorny issue that we're going to have to require buy in from all the people that care about that, including consumers. Again, if you're a consumer and you have sort of one set of benefits if you go into this system and another set of benefits if you go into the tort system, there are some equal protection things that really have to be worked out. So, Ed and all of you, I look forward to that research coming from you.

But I think that sales job is really important. One of the models that I've seen recently that I thought was really expertly done that I recommend you to think about as

we move forward with this debate is a project that was done in Australia over the last couple of years to really develop a core curriculum for patient safety. The problem identified by the Australians, I think brilliantly, was that we're not really going to have this transformation in the way that we think about medical error and compensation issues until we really retrain our health care workforce about the basics of system science and patient-centered care. And so they developed a curriculum. They did a lot of process around developing it. But then they took it out to the public, and then through, really just about a year, through a really multi-layered iterated process got a lot of buy-in from a lot of pieces of the public. And it didn't take long. It took a year. There was a lot of buy-in there, and I think that this project really needs something like this as we move forward. Stop there and open up to questions I guess.

(Applause.)

MR. BARRINGER: All right, let's see if there's some questions from people in the audience, yes?

Q: One thing that we all –

MR. BARRINGER: We have the microphones coming.

Q: One thing we all have to remember is that in individual cases –

MR. BARRINGER: Now, could you tell us what your name is?

Q: I'm Tom Connolly (sp). I've practiced internal medicine here in DC for 35 years. One of the things we have to remember is that clinical medicine in individual cases is not an exact science. The example Mr. Erichsen from Denmark used is the use of casts versus internal fixation in the fractured foot. Honestly, cases like that happen where you might have ten qualified orthopedists, five of whom would try internal fixation, five of whom would try the cast. And in both situations, you'd have some bad outcomes on both sides.

If we go to a pure no-fault system, we're going to pay for all those bad outcomes, so what we've got to do is to get away from the terrible system we have now where there are hired guns screaming at each other on both sides in front of incompetent juries, and move to something where we are in between – not where we pay for everything, but I think the idea of all of this, the problem, is how to work out a way in between where you can take individual judgments into consideration. It's not all purely – everything that goes bad is not all pure bad behavior on the part of physicians. A lot is, but not all of it.

TROYEN BRENNAN: Any thoughts about that from the panel's point of view?

MR. SLEIGH: I do. And actually my thought comes from my experience as working as a machinist. Starting in the 1970s in my industry – printing press manufacturing – we started doing quality control. Quality control is based on data. If

you don't have data, you can't do quality control. It becomes continuous, and it starts from day one, and then you get a little better. And you get better and you get better. And I agree with you that medicine is not a science. It's not building a printing press. But, without the information, you have no place to even start talking about quality improvements. So I think that I don't disagree with you.

And I also should have said that one of the experiences that we have in the labor movement is that we are subject to a specialty court system. The National Labor Relations Act established administrative law judges to settle labor disputes. And so we go to ALJs who have expertise in labor issues, not just to any jury, and that's been very effective. So my two points are there on the quality side, we have to find a mechanism so the doctors feel comfortable about providing information – collecting it and providing information, so that they can learn from one another, and that patients can see which doctor has done a better job than others.

TROYEN BRENNAN: Dave.

MR. SWANKIN: Your comment – I thought – it raised a couple of thoughts in my mind thinking about the Harvard presentation. One of them that I'd just suggest you take a hard look at – the system as you've devised is a two-level administrative. You make it hard to get into court, but you keep it at two levels, the first the smaller panel reviews it and if you don't like the outcome there, you can appeal it to the larger panel. So it's two administrative panels that see these cases. If you look at our experience, when you were presenting that, I thought it was the HMO model, which is kind of two administrative reviews of coverage decisions.

On HMO complaints, I'm not an expert in it but I remember the very first year Texas reported 50 percent of the cases were overturned at the second level. If you look at the OSHA review level, 50 percent of the cases are overturned at the second level. I'm an attorney. I hate that kind of an appeal system. I think that you've got to develop a system where it's almost always right down below. I hate any system where decisions at the first level are often overturned. I just think you lose confidence in the entire system when that happens. If you've got a 50-50 chance to have it changed at the next level, you might as well go there. It has nothing to do with right or wrong. I don't like the decision of the first panel. I'm going to take it to the second panel “and take my chances” is how people think when they are in this type of review system. I just wish you guys would think a little bit more about how you could force that decision to be so correct at the bottom level, and that you anticipated numbers in the magnitude of say 2 percent of the cases that get changed on review. It puts a lot of responsibility on that first panel to do it right.

You're trying to replace the alleged unfairness of the jury system. Well, people aren't going to be happy if they feel it's a crap shoot. So I think that's something that I would look at before I went forward with this.

The second one – and it's along the same line. In your system, you have the five connections to patient safety. And one of them that you described as the most controversial is whether to pass information on to licensing boards and credentialing boards. I know in medicine – and Troy, you should know this really well because of the work you've done with ABIM – there's the ABMS boards all trying to do a much better job of maintenance of competence. The strength of that whole program is the collection and evaluation of clinical experience data. And I think to cut off the certification boards and the licensing boards. I probably feel differently than you on the licensing board. But you absolutely have to give all the data you collect to the certification boards because they can really use it to upgrade quality one-by-one of all the physicians that are board-certified, which is most of them.

And I would give all the data to the licensing boards. The fact that they haven't done anything with this type of data in the past, doesn't mean they shouldn't. And you come from a state (Massachusetts) where they're at least trying to do something with quality data. So I think that as you develop the theme, I would clearly vote to include that controversial number three as one of the groups that gets all the data.

TROYEN BRENNAN: Martie?

MR. HATLIE: This strikes me as just a perfect example of how even though we're here talking about moving beyond blame and moving towards systems that really don't focus on behavior, it creeps back into all of our discussion and all of our thinking about it in this country. I really like the idea of the Chinese wall or the Berlin Wall, I guess it was referred to today, because it really isn't about behavior anymore when you're just compensating for those injuries. And it struck me as I was listening to that presentation and the comments that were made I think by both Martin and Dr. Erichsen or Professor Erichsen that physicians and nurses are helping patients actually fill out their claims forms in those countries. And you know, it struck me that perhaps they're doing that really to avoid having a complaint filed against them on the other side of the Berlin Wall. And that might be actually a fairly patient-centered thing. And that could be a real incentive to having the kinds of discussions that we're not having now that are respectful, that are compassionate, that are really healing for both sides. And so, I don't know that I've really made up my mind yet about the Berlin Wall, but I really have a much deeper appreciation of the benefits of it after today.

MR. BARRINGER: Some other questions. Yes, sir? No, right there. The man who they're trying to hand the microphone to you.

Q: My name is Donald Patrick. I'm the executive director of the medical board in Texas. I'm an MD/JD so – work both sides of the street. (Laughter.) And something that you said Mr. Sleigh that really struck me was that you used the word accountability. And I just want to let you know that I made a speech ten days ago to the A&M medical school, and the title of it was Higher Powers. And what was the highest power – accountability. There's a certain amount of ethical ability we have born with, a certain amount we develop or get worse as we grow up. But no matter how good you are in a

room all by yourself, you're better when someone is watching you. And that's what medicine needs to develop a database, an electronic database, work out a way to deal with the patient safety issues. But we have to have a way to know what we're doing all over this country, sort of like what they do in Denmark and Sweden. They know what's going on in their country. We do not know. We have no idea.

I don't know what's going on in my hospital when I was working in it. I'm a neurosurgeon. Five or six hospitals – I still didn't – five or six neurosurgeons in the hospital, I still didn't know what they were doing. So accountability is the key, and as long as we keep that in mind, I don't think we'll be in a lot of trouble the direction that we head in the future.

MR. BARRINGER: Yes, ma'am.

Q: I'd actually just like to make a quick statement.

MR. BARRINGER: They're probably not going to be able to hear you in the back unless you wait for the mike.

Q: I just want to make a quick statement. My name is Lisa Miller. I'm a practicing nurse, midwife, and nurse educator, and I teach in the area of obstetrics and patient safety. There are so many important people in the room – policymakers, people that are much better brains than I – and I'd like to put out a call that we really think also about encouraging the professional organizations to come forward. We heard from our colleagues across the ocean about this concept of best practices. And contrary to what one speaker alluded to, quite frankly, there are best practices, and there is evidence for much of what we do, at least in obstetrics. And yet, many of our professional organizations are loath to go on record and publish accurate, updateable, and true technical bulletins.

ACOG does a fairly good job, but ACOG, ACNM (inaudible) organizations, well, I'm going to give my opinion. You may not agree and it's okay. But I know that many people in our professional organizations are afraid to publish evidence-based best practices for fear that they will be used against providers in litigation, used against their members in litigation. My point is this. As a member of two professional organizations that I pay money to, I want you to tell me best practices. If you can have the time to review all the data and review the evidence and tell me what the best way is to do something based on current evidence, publish it. Not only do I think I want the information, I want all my colleagues to follow it. And if they don't, there should be sanctions. So that's just the opinion of a clinician, not a politician or a board member. Thank you. (Applause.)

TROYEN BRENNAN: Thank you.

(Audio break, tape change.)

Q: (In progress) – and put forth a – I suspect we know more about our doctors than somebody from an engineering background might appreciate because I find that engineers approach the world – if they can't measure it, it doesn't count. And I do think that – I'm not being pejorative here; it's just a fact of – some of my best friends are engineers, what can I say? (Laughter.) But the point is that you do measure interactions every time you go to the doctor.

I think that we have developed a system over the last 40 years – and I have been in practice almost that long – where we are divorced from the immediate feedback you can give to your doctor, which regulates his own behavior, which is you pay his bill. And right now, we don't care. We go to a doctor, it goes to the insurance, and so on and so forth; it all disappears into the fancy work, and so on. And I'm a practicing all-out (patient ?). I don't do surgery. I don't cut anybody. I will stitch you up, but I don't make cuts, et cetera.

You mentioned about standards. The pediatricians about 10 years ago published what should you do if you have a febrile child under certain ages. Well, the ER physicians followed those rules; most practicing pediatricians didn't. If you look 10 years down the pike, who is identifying very sick infants? Actually, both groups are doing about the same. What is the difference? In the office you follow people up; in the emergency room you don't. So there is a huge discrepancy between what our expectations can and should be.

I don't know how to factor it all together but I do know I am a very lousy diplomat. When I first in practice, if I turned somebody off I disappeared. I was employed by a thousand people or two thousand people, so I had to be on my best behavior and I did my best job all of the time. Now I sign up with insurance companies and I am on their panel and I am very well removed from this immediate feedback kind of thing. I think it is to the detriment of all of us, both as physicians, and as patients.

I hate consumers and I hate providers, by the way. (Scattered laughter.) But at any rate, that is my biases. I like to do a good job, and I like the feedback from my patients that tell me I am doing a good job. And when I get that I will do a good job, and when I don't get it, I am afraid I may (walk ?).

MR. HATLIE: In Europe they would call you a citizen, so maybe that would be the default term for here today.

MR. SLEIGH: (Chuckles.) Well, one of my many hats is as the head of our multi-employer healthcare plan. In addition to bargaining benefits, I run a healthcare plan. And as an insurer we get claims data. It turns out claims data is really not a very good proxy for what actually happens in the doctor's office, but it is the only data that we have.

I think that David's point that the medical specialty societies in fact have lots of outcome data, and that is really what you need in order to assess the quality. It's not just

about claims and the cost of the procedures. It is about the intersection of the costs and the outcomes. And here we need to have some sort of public consensus that that information is a public good, and it ought to be supplied. If it's part of a quid pro quo on medical practice, then we would support that.

One other thing – my job is to represent workers. What we hear from workers is dissatisfaction in the workplace. We just ran a poll not too long ago of doctors because, believe it or not, we think that that is a great group to organize. And doctors are showing incredible dissatisfaction with their job. They are under incredible pressure from Medicare, from the insurance companies, from the pharmaceutical companies, from the patients. The lack of satisfaction on the job, whether it's the nurse midwives or primary care physicians is close to an all-time low. So I do think that there is an opportunity here to put together an unusual coalition of sort of right and left to move an issue today.

MR. BRENNAN: I just know that Stephen – he has got a lot of jobs, but if you read the bios, he graduated in 1986 I think from college, and a little bit later it says he has been a member of the machinist union since 1974. That guy started as a machinist when he was 10 years old.

MR. SLEIGH: Ten years old, exactly. (Laughter.)

MR. BRENNAN: Yes, back there. No, I am sorry, this fellow right here next to you. He has had his hand up persistently.

Q: I am Brian Avin and I am a neurologist in Maryland. And I would like to expand a little bit on something that we really haven't touched on – doesn't pertain exactly to what we are talking today, but we mentioned accountability. And there are two areas that we haven't discussed, and one is the accountability of ourselves as individual citizens, patients. And I would say that about 50 percent of illness is self-induced. So when we talk about medical costs, I can't imagine any system that could accommodate the costs that we generate when we don't make ourselves accountable for our lifestyles.

And the second issue is the insurance companies, the healthcare insurance companies who are raping the medical system, and they need to be held accountable.

MR. BRENNAN: A couple more questions. Way in the back there. Yes, that gentleman who is sitting in the very back.

Q: Hi, I am Doug White, and I am a physician in my part-time capacity I edit a journal and an academic discipline as well. But I wanted to follow-up in this issue of physician behavior. One of the strengths I see of an administrative court system is that physicians might just have the confidence that the information that were assembled to you through HIT or that the evidence-based practice habits that they produce could be used to protect them as opposed to impugn them, which is really one of the great tragedies of the current system we have right now.

If you produce a textbook explanation for your behavior that is not usually adequate defense against another textbook that will be produced to defend – it is just the context that you are judged in; it doesn't balance out right now. And in an administrative system, those disputes could be adjudicated internally through the process ahead of time so knowing going in ad hoc into your case, you would know what the outcome would be basically. In other words, without prejudging ahead of time which textbook would be cited on, the administrative court would have to make a decision instead of making everything ad hoc.

The other thing is physicians will conform. I was a little bit skeptical about this myself although I forget that when you go through a training system, you basically do whatever your chief resident wants you to do or you get whacked over the head; it's just that there is no systematic conformity.

But physicians are very conforming individuals. They are pre-selected to do that. In fact, there are studies emerging now that you can change physician behavior for relatively modest sums – 2 to 5 percent kind of reimbursement change will – you will make any physician perform like a Pavlovian dog it turns out.

Now, that is a pleasant discovery, but it is inspiring to think that physicians will adapt to things and they will change if there are only modest kinds of incentives involved in that. And if you free them up to produce the evidence base – I mean, the doctors know who all the bad practice habits are coming from and what they represent. They know good medicine when they see it, and they will produce whatever they are incentivized to do. So I encourage everybody outside of the cloister, so to speak, to pursue these elements and liberate doctors to cooperate with these processes. I think that is very important.

MR. BRENNAN: Okay, well, if there aren't any other questions or comments, then I think Phil Howard is going to come and give some concluding remarks. Can we have a hand for the panel?

(Applause.)

MR. BARRINGER: Before Philip gives some concluding remarks, I want to just thank you all again for your time in being here with us this afternoon. I have really enjoyed the session, and I hope that you all have as well.

Just a couple of housekeeping points: I hope that you will fill out the evaluation sheet, which is in the front pocket of your orange binders. I think it is a yellow sheet. We would love to have all of those. You can either leave them on your seat, or there is a box downstairs on the way out. Secondly, we are going to have a transcript made of today's session and we will send that out when it is done. That should be in a couple of weeks. And then the final point is that we will have copies of slides that we can make

available, and we will send those out to the group. So thank you again for being here and here is Philip Howard.

(Applause.)

PHILIP HOWARD: I would like to reiterate Paul's thank you to all of you for coming. It's been a great discussion, particularly the end. It is wonderful to get the different perspectives and to understand that perhaps the stalemate we find ourselves in isn't inevitable, that people of good will from different points of view might in fact be able to come together towards a much better solution.

I think the discussion today has certainly been illuminating, listening to how other countries do it and such. I found it gratifying that it confirmed one of my deep-felt beliefs that America is like the California to the rest of the world in supporting bad values – (laughter) – in this case, exporting defensive medicine to Sweden as the result of the training of physicians over here.

But I also think that just the fact of this meeting is important – all of the different constituents coming together. You know, so much of the current debate seems driven by the initial forces of how the current system works. And in order to move beyond that, we have to see that there are other possibilities, that there are other ways to skin the cat, there are other goals that this system is not meeting.

We have heard Jackson talk about the perverse incentives of the current system, which has become a kind of lose-lose system of liability that doesn't provide the deterrent effect, doesn't really compensate fairly, and makes no choices needed to improve the system.

I am with Stephen Sleight in saying that one of the problems the current system has is that no one is accountable. I think that is a very important problem, but I think that is only a subset of a larger point, which is that in the current system we don't have any mechanism for making deliberate choices.

We are not making the choices of what is good care and what is not, by which we can hold people accountable. We are not making the choices about what kind of care is effective and should be, what we should spend money on, and what kind of care is not effective.

And as we all leave this room and move forward, I hope that we will think about the fact that today really nobody is in charge. We have this system that is 16 percent of our budget growing higher, killing the workers of America – they can't afford it – making it so that 45 million people have no health insurance at all, and yet we don't really have the mechanisms to make the choices to fix it.

Hopefully we can continue to talk together and to work together, and begin to help our political leaders make some of the choices that other countries have made in

coming up with a new system that will serve all of the constituencies in what is probably the most important area of our domestic lives, healthcare. Thank you again for coming.

(Applause.)

(END)