NCOIL RESOLUTION ON MEDICAL MALPRACTICE AND PATIENT SAFETY
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Everyone is in favor of patient safety. The only direct beneficiaries of medical error are personal injury attorneys. NCOIL should be commended for its efforts in this arena and I appreciate the opportunity to participate in this discussion. I will make specific comments about the NCOIL proposed resolution in a moment, but I would like to begin with the general context in which this measure has been offered.

Public consciousness about patient safety was dramatically heightened by the 1999 publication of the Institute of Medicine monograph, *To Err is Human.* This study famously declared that 44,000-98,000 Americans die every year due to medical negligence. This is not true. Let me explain.

The deaths of 180 patients from among 32,000 patients in New York State in 1984 were characterized as negligent. These 180 were then extrapolated to 98,000 nationally. Unfortunately, the Harvard reviewers who did the study had a 90% discordance rate in their internal estimation of the presence or absence of medical negligence. When a second set of Harvard reviewers examined the same set of charts they could not find the same medical errors as the initial reviewers, but found about the same number of concerns. Though the authors were satisfied with this outcome, it is analogous to saying it doesn't matter whether you convict the guilty or the innocent, as long as the incarceration rate matches the crime rate.

The same authors repeated their study in Colorado and Utah and published the result in 1991. Deaths due to medical error (using the same flawed methods of the initial study) were calculated to be 44,000. Thus, if you believe this study, and you should not, the 55% improvement between 1984 and 1991 exceeds the stretch goals set in the 1999 publication.

Even more important, the study concluded *there is no relation whatever between the presence or absence of medical negligence* and the outcome of medical malpractice litigation. The only variable correlated with outcome is the degree of injury. Those with serious adverse outcomes were likely to be compensated irrespective of whether their injury was caused by medical negligence.

This is important to us today for two reasons:

First, we must separate valid issues of patient safety from our deeply flawed medical malpractice system. Currently, malpractice litigation does not identify bad doctors. Approximately three quarters of all malpractice claims are found to be without merit and even those that do result in indemnity often do not reflect medical negligence.

Second, we must not allow the benefits of enhanced patient safety to be conflated with medical malpractice litigation. The onerous nature of the system significantly impedes free exchange of information about potential risks and improved systems of patient care delivery. Troyen Brennan, one of the principal authors of the Harvard Medical Practice Study, wrote earlier this year: *"Our legal system has infected health care with a debilitating distrust. This distrust has spawned a culture of secrecy and waste in 'defensive medicine', undermining the quality of care and contributing to skyrocketing costs and reduced patient access."*

Moreover, we should take note that today's concerns about patient safety have arisen despite a veritable torrent of litigation against America's physicians. 30-40% of high-risk specialists reported a claim last year, and the year before, and will this year and the next. Medical malpractice litigation does not make America's healthcare safer.

There are, nonetheless, a number of valuable insights in the IOM study that should guide us in our deliberations today. The study noted: *"One of the greatest contributors to accidents in any industry including health care is human error. However, saying that an accident is due to human error is not the same as assigning blames because most human errors are induced by system failures"* (p. 55). The authors called for peer review protections for data related to patient safety and made an observation that is especially pertinent today: "When someone needs medical care, the worst quality is no care at all." (p.21)

The Doctors Company would vigorously support NCOIL in calling for legislation that would create confidential voluntary reporting systems that would collect and analyze the data and provide feedback on patient safety improvement strategies. Such data should be confidential and legally protected. This kind of legislation is awaiting passage in Congress and should be strongly supported.

Increased funding for medical boards would be helpful as long as the funds raised through licensure fees do not simply go into the state's general funds. Education of medical professionals regarding evolving standards of care and enhanced patient outcomes should be encouraged and funded, beginning in medical school and continuing throughout medical training.

Opening the National Practitioner Data Bank to the public is unlikely to be helpful as long as there is so little correlation between malpractice litigation and medical outcomes. The NPDB was not designed as a public use entity. It contains limited information and was intended to be a flagging system for hospitals and other credentialing organizations that are in a position to obtain detailed information on the incident. At present, doctors rarely take the opportunity of filing their own statement in the Data Bank record. If the NPDB is ever opened to the public, it should be on a prospective basis with physician responses readily available. Any reform of the NPDB should also include raising the reporting threshold so that only significant awards are reflected. Misleading information can be more dangerous than limited information.

Finally, while the VA efforts on patient disclosure are of great interest, we should recognize they occur under the protection of the Federal Tort Claims Act, in a dependent patient population with effective access to care, in an environment of institutional rather than personal liability, and have been widely implemented too recently to judge their effect on malpractice claims.

In conclusion, I commend NCOIL for its efforts on behalf of patient safety and urge you to move forward with effective legislation that will create confidential voluntary reporting systems to collect and analyze data, provide feedback on patient safety improvement strategies and not be defeated in the name of our failed system of medical malpractice litigation.