

Testimony of Paul J. Barringer, III
Before the U.S. House of Representatives
Committee on Energy and Commerce, Subcommittee on Health
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Thank you for this opportunity to discuss innovative approaches to improving America's medical liability system.

I appear as General Counsel of Common Good, a legal reform coalition. We are a bipartisan organization – former Senators Howard Baker and Bill Bradley are members of our Advisory Board, as are former Senator George McGovern and Representative Newt Gingrich – funded primarily by philanthropic foundations. Our largest financial supporter is the Robert Wood Johnson Foundation, which is currently underwriting a two-year collaborative effort between our organization and the Harvard School of Public Health to refine a conceptual proposal for developing specialized health courts to resolve medical injury disputes. Common Good has been active nationally since 2002 in promoting the development of specialized health courts.

The debate over medical malpractice reform remains one of the most polarized in American politics. Frequently lost in partisan disagreements, however, is this key fact: America's approach to resolving medical injury disputes works poorly for consumers and health care providers. Many preventable injuries occur today in the course of health care treatment, yet few injured patients file a claim. Even fewer receive any compensation, and those who do never see the full award. When attorney fees and other administrative costs are included, only 46 cents of every dollar spent in tort cases in 2003 reached injured claimants.¹

The system also fails health care providers. In particular, today's system does a poor job in distinguishing negligent from non-negligent care, providing ambiguous

signals to health care providers about what it will take to avoid litigation, and encouraging costly “defensive medicine.”² Moreover, the system discourages providers from disclosing information about errors or “near misses” (those errors that do not result in any harm).³ This is unfortunate, as patient safety experts identify such reporting as a key element in comprehensive efforts to improve quality in the health care system. This chilling effect on information disclosure has led the Institute of Medicine (IOM) and others to identify the existing legal system as a major impediment to system-wide patient safety enhancements.^{4,5}

Since the late 1990s, the concepts of patient safety and health care quality have become increasingly important drivers in health policy. Perhaps no single event galvanized public interest in safety and quality more than the IOM’s 1999 publication of *To Err is Human: Building a Safer Health System*.⁶ In this landmark report, the IOM revealed that as many as 98,000 people die unnecessarily every year in American hospitals because of medical errors. The report concluded that most errors are caused not by individual providers but rather by breakdowns in larger systems of care.⁷ This report stimulated significant political interest in safety and quality, and has led to the development and introduction of numerous legislative initiatives to address these issues.⁸

As interest in patient safety has increased, so too has the awareness that health care quality and the medical malpractice system are connected. To better prevent medical errors, experts say, more information needs to be disclosed about errors and near misses.⁹ Only with such data can hospitals and providers analyze the patterns and frequency of medical error and focus on fixing the system-wide breakdowns that lead to errors. However, fear of litigation in the current system impedes the open exchange of

information about errors and near misses. Significantly, the IOM identified the legal system as a major impediment to improved quality in a 2002 report titled, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*. “There is widespread agreement,” the report stated, “that the current system of tort liability is a poor way to prevent and redress injury resulting from medical error.”¹⁰ The report called on Congress to charter demonstration projects to explore new ways to resolve medical injury cases.

Growing out of the IOM’s recommendations, support has continued to increase for experimenting with new approaches to resolving medical malpractice disputes, including the development of specialized health courts. Common Good, founded and chaired by attorney and author Philip K. Howard, has been the leading proponent of the health court concept and, as stated previously, has been working with the Harvard School of Public Health to refine the health court concept and cultivate stakeholder support.¹¹

As currently envisioned,¹² the health court concept includes the following elements: trained judges relying on neutral experts to adjudicate malpractice disputes; reliance on a new standard of liability – “avoidability” – that is broader than negligence; explicit use of evidence-based guidelines to aid decision-making; damage schedules for compensating injured claimants; and a range of linkages to patient safety structures and initiatives. Generally, the proposed system would rely to a much greater extent than the current system on administrative processes for determining liability and compensation. Key reasons for this include the greater efficiency associated with administrative compensation systems as well as their ability to award compensation to injured claimants more rapidly.^{13,14}

A core element of the health court concept is that health court judges should have expertise in medical issues. Judges would be selected through an independent and nonpartisan screening process, and sitting judges would participate in additional training and education to ensure their continued understanding of the evolving issues in health care. These judges would make decisions about proper standards of care, and would issue written rulings of these decisions, which would provide guidance for future cases and in turn would help promote consistency from case to case. Over time a body of law would develop that would differentiate between what is good medical practice and what falls short, and this would send clear and consistent signals to health care providers.¹⁵ By concretely defining and promoting consistent standards, this process could also help reduce variations in medical practice patterns across populations and geographic areas, and improve standards of care both regionally and nationally. It could also help reduce costly defensive practices, and more broadly provide a framework for cost-containment.

A record of these decisions and other de-identified data from claims would be reported to patient safety authorities (and back to providers) for root cause analyses of what went wrong and why. Standardized event reporting would ensure that the appropriate information is reported. In the aggregate, such data would also help facilitate epidemiological analyses for purposes of developing health quality improvement initiatives and preventive practices.

As we envision it, compensation decisions in a health court system would be based on a standard other than negligence. Health care treatment is considered “negligent” today if the provider failed to exercise the level of care that a reasonable person would have exercised in the same circumstances. Many experts have identified

the negligence standard as contributing to an overemphasis on blaming providers for adverse events that have occurred in treatment. This is inappropriate, studies suggest, because most errors result not from individual malfeasance but rather due to breakdowns in systems of care.¹⁶

Of particular promise moving forward is the concept of “avoidability,” which is employed in Scandinavia. Under this approach, a medical injury is deemed compensable if it could have been prevented (or “avoided”) had the doctor followed the best medical practice – whether or not the treatment was negligent. Although avoidability is broader than negligence as a theory of liability, it does not constitute absolute or strict liability for every bad outcome. Only those injuries which are caused by treatment and which could have been prevented (avoided) are eligible for compensation.¹⁷

Use of the liberalized avoidability standard of recovery would likely help expand the number of patients who receive compensation. Application of the avoidability standard should also help lessen the emphasis on blaming individual providers. Unlike a negligent event, an avoidable event does not necessarily implicate blame on the provider involved (since even the best provider can experience an avoidable event). In Denmark and Sweden, use of the avoidability standard has helped create a much less combative and litigious environment between physicians and patients, and has helped provide an incentive for providers to help their patients with the claims process and ensure that they receive appropriate compensation for avoidable injuries.¹⁸

In today’s medical malpractice system, each party typically retains its own expert witnesses. These competing experts-for-hire often provide distorted or conflicting advice that can confuse juries and add time and expense to the process by which disputes are

resolved. Under the health court approach, by contrast, health court judges would consult with neutral medical experts to determine the standard of care in medical injury cases. These expert witnesses would be compensated by the court, and they could be held accountable to a standard of objectivity by regulatory authorities.

Of course, determining the appropriate standard of care in a specific case can be a complex undertaking, regardless of the expertise of the decision-maker. Also, there may be several reasonable courses of treatment in a particular circumstance. To aid health court judges in reaching consistent decisions from case to case, judges would consult clinical practice guidelines based on evidence-based practice standards, such as those published and disseminated by the National Guideline Clearinghouse at the U.S. Agency for Healthcare Research and Quality, or by medical specialty organizations.¹⁹

Based on reviews of the best available scientific evidence about how adverse events occur and the extent to which they are preventable, medical experts and key stakeholders could also work together to develop compensability recommendations for health court judges to apply, including the development of so-called “avoidable classes of events” or “ACEs” (predetermined malpractice scenarios that have been compiled by experts to expedite the claims process in clear-cut cases).^{20,21} Clear-cut cases would be fast-tracked for compensation, and efforts would be made to encourage early offers of compensation. In particular, claims against institutional health care providers (such as a hospital or integrated delivery system) would begin with consideration of the claim internally by a review board associated with the clinical enterprise. In clear and uncontested cases, the review board would designate the injury as an ACE, and the provider would be ordered to pay damages according to the appropriate compensation

schedule. In cases in which the circumstances of injury were not straightforward, the case would be referred to a health court.

In today's system, few injured patients are compensated and there is little consistency in awards from case to case. To promote horizontal equity, the health court system would have a schedule of benefits specifying a range of values for specific types of injuries and taking into account patient circumstances. To ensure fairness, this compensation schedule could be set by an independent body and periodically updated. Individual awards would likely be smaller on average than the awards in the current system, but having compensation schedules would ensure that more plaintiffs had access to reasonable compensation. At the same time, use of a compensation schedule could help reduce the percentage of total system costs devoted to administrative expenses. Comparable administrative compensation systems in the U.S. and overseas devote far less to administrative expenses than the existing tort system.²² Research with respect to Colorado and Utah claims has indicated that a patient compensation system employing compensation schedules and an avoidability standard of liability could be implemented in the U.S. at a total system cost comparable to that of the existing system, while compensating far more patients.²³

The health court concept calls for replacing the jury with a judicial decision-maker. The constitutional authority to create an administrative compensation system in place of a traditional jury trial is clear where it is part of a regulatory plan to improve health care.²⁴ Congress has broad powers to authorize pilot projects for specialized health tribunals under the Spending Clause,²⁵ and under the Commerce Clause because medical injury litigation is economic activity that itself constitutes, and affects, interstate

commerce.²⁶ Contrary state law provisions, if any, would be pre-empted under the Supremacy Clause.²⁷ Moreover, similar federal administrative compensation systems have been upheld against constitutional challenge.²⁸

A number of prominent public health experts and scholars have expressed support for the health court concept,²⁹ as have numerous political leaders and institutions from both sides of the aisle. For example, the Progressive Policy Institute, a Democratic think tank known in the 1990s as President Clinton's "idea mill," has endorsed the concept, as has the Manhattan Institute, a conservative-leaning think tank. Numerous health care groups have expressed support as well, including the Joint Commission on Accreditation of Healthcare Organizations, the American Association of Retired Persons, and many state and national medical groups.

The health court concept has also garnered significant media coverage and endorsements. Scores of newspaper and magazine articles have devoted attention to the concept, and a number of prominent media outlets have expressed their support. In July 2005, for example, *USA Today* opined that "Health courts' offer cure." The opinion piece went on to say that "[h]ealth courts could show the way for quicker and fairer compensation to the deserving, and they might reduce the incentive for doctors to engage in defensive medicine. ... Starting the experiment is the right medicine for an ailing system."³⁰ *The Economist* has called the health court concept "a sensible idea" that "ought to make the system less capricious."³¹ And *The New York Times* has urged Congress to "push for a wide range of demonstration projects" for new malpractice reform alternatives, including health courts.³²

Several bills have been introduced in Congress to create health court pilot projects. In the House of Representatives, Representative Mac Thornberry (R-TX) has introduced legislation to test new model health care tribunals at the state level.³³ In the Senate, Senator Max Baucus (D-MT) and Senator Michael Enzi (R-WY), Chairman of the Senate Committee on Health, Education, Labor, and Pensions, have introduced a bill to facilitate state level experimentation with a number of alternatives to current medical malpractice litigation, including health courts, early offer programs, and scheduled compensation.³⁴ Hearings were recently held to consider this legislation. Senator John Cornyn (R-TX) is expected to introduce legislation shortly as well. Finally, legislation to create health courts (or explore the feasibility of creating health courts) has been introduced in a number of states, including Illinois, Maryland, New Jersey, Pennsylvania, and Virginia, and additional state legislative activity is expected this year and next.

The debate over medical malpractice reform will almost certainly continue to be a very polarized one. As awareness continues to grow about the ways in which the current system fails patients and providers, however, support will likely continue to increase for exploring new alternatives that can benefit consumers, provide relief to providers, and help advance – rather than impede – quality improvement in health care. An administrative health court system represents a promising approach to compensating injured patients and establishing greater reliability in medical justice. With public support and political leadership, this new approach to medical justice can become a reality, both through pilot projects and as part of broader system reforms.

Thank you.

¹ *U.S. Tort Costs: 2003 Update 17* (Tillinghast-Towers Perrin 2003).

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- ² For example, one out of four baseless claims result in payment, according a recent study by Harvard School of Public Health researchers. See David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, *New England Journal of Medicine*, vol. 354; May 2006, p. 2029. For information about defensive medicine, see, e.g., Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?* May 1996 *Quarterly Journal of Economics* 353-390. It is important to note that there are substantial variances in estimates of what defensive medicine costs the U.S. health care system. The article cited above represents perhaps the highest estimate, although the validity of this estimate has been challenged. There is little question, however, that defensive medicine does in fact occur. See e.g., David M. Studdert, Michelle M. Mello, William M. Sage, Catherine M. DesRoches, Jordon Peugh, Kinga Zapert, & Troyen A. Brennan, *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment* 293 *Journal of the American Medical Association* 2609-2617 (2005).
- ³ *Crossing the Quality Chasm: A New Health System for the 21st Century*, Institute of Medicine 219 (National Academies Press 2001).
- ⁴ *Crossing the Quality Chasm: A New Health System for the 21st Century*, Institute of Medicine 219 (National Academies Press 2001).
- ⁵ *Health Care At The Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury* 27 (Joint Commission on the Accreditation of Healthcare Organizations 2005).
- ⁶ *To Err is Human: Building a Safer Health System*, Institute of Medicine (Linda T. Kohn, Janet M. Corrigan, & Molla S. Donaldson eds., National Academies Press 2000).
- ⁷ *To Err is Human: Building a Safer Health System*, Institute of Medicine 1 (Linda T. Kohn, Janet M. Corrigan, & Molla S. Donaldson eds., National Academies Press 2000).
- ⁸ See, e.g., The Patient Safety and Quality Improvement Act of 2005, P.L. 109-41, signed into law July 29, 2005.
- ⁹ *Crossing the Quality Chasm: A New Health System for the 21st Century*, Institute of Medicine 219 (National Academies Press 2001).
- ¹⁰ *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*, Institute of Medicine 82 (Janet M. Corrigan, Ann Greiner, & Shari M. Erickson eds., National Academies Press 2002).
- ¹¹ *Harvard School of Public Health and Common Good to Develop New Medical Injury Compensation System*, Harvard School of Public Health Press Release, January 10, 2005. <http://www.hsph.harvard.edu/press/releases/press001102005A.html.html>
- ¹² More information about the evolving health court proposal is available at <http://cgood.org/healthcare.html>.
- ¹³ Randall R. Bovbjerg, Frank A. Sloan, & Peter J. Rankin, *Administrative Performance of "No-Fault" Compensation for Medical Injury*, 60(2) *Law and Contemporary Problems* 71, 90-98 (1997).
- ¹⁴ David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286(2) *Journal of the American Medical Association* 217, 219 (2001).
- ¹⁵ Note that appeals to resolve disputes about the standard of care within and across state lines could be made to a dedicated court of medical appeals, potentially at the federal level. Similar to the current system, both parties would have lawyers representing them.
- ¹⁶ *To Err is Human: Building a Safer Health System*, Institute of Medicine 51 (Linda T. Kohn, Janet M. Corrigan, & Molla S. Donaldson eds., National Academies Press 2000).
- ¹⁷ David M. Studdert, E.J. Thomas, B.I. Zhar, J.P. Newhouse, P.C. Weiler, & Troyen A. Brennan, *Can the United States Afford a 'No-Fault' System of Compensation for Medical Injury?*, 60(2) *Law & Contemporary Problems* 1, 3-7 (1997).
- ¹⁸ *Administrative Approaches to Compensating for Medical Injury: National and International Perspectives*, Event Transcript 16, 22, Public Forum held by Common Good-Harvard School of Public Health at Carnegie Endowment for International Peace, Washington, D.C., October 31, 2005.
- ¹⁹ National Guideline Clearinghouse, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, <http://www.guideline.gov/>.
- ²⁰ Randall R. Bovbjerg, Laurence R. Tancredi, & Daniel S. Gaylin, *Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System*, 265(21) *Journal of the American Medical Association* 2836-2843 (1991).

²¹ Randall R. Bovbjerg & Laurence R. Tancredi. *Rethinking responsibility for patient injury: accelerated-compensation events, a malpractice and quality reform ripe for a test*, 54(1-2) Law & Contemporary Problems 147-177 (1991).

²² See, e.g., Randall R. Bovbjerg, Frank A. Sloan, & Peter J. Rankin, *Administrative Performance of "No-Fault" Compensation for Medical Injury*, 60(2) Law and Contemporary Problems 71, 90-98 (1997). *Administrative Approaches to Compensating for Medical Injury: National and International Perspectives*, Event transcript 21, Public Forum held by Common Good-Harvard School of Public Health at Carnegie Endowment for International Peace, Washington, D.C., October 31, 2005.

²³ David M. Studdert, Eric J. Thomas, Helen R. Burstin, Brett I.W. Zbar, E. John Orav, & Troyen A. Brennan, *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38(3) Medical Care 250-260 (2000).

²⁴ As part of Common Good's ongoing Robert Wood Johnson Foundation project, Professor E. Don Elliott of the Yale Law School has developed the constitutional analysis on which this section is based.

²⁵ For example, see *South Dakota v. Dole*, 483 U.S. 203 (1987), upholding the federal government's conditioning state receipt of federal highway funds on adopting a drinking age of 21.

²⁶ See *Gonzales v. Raich*, 125 S.Ct. 2195 (2005); *United States v. Lopez*, 514 U.S. 549 (1995).

²⁷ See *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238 (1984); *Pennsylvania v. Nelson*, 350 U.S. 497 (1956). Note that whether or not a state could assign malpractice claims to an administrative entity without violating 7th Amendment rights to a jury trial would depend in part on whether the Supreme Court would characterize the rights at issue as "private" or "public" rights. Essentially, private rights involve the obligations of one individual to another, whereas public rights involve issues relating to broad public purposes. Significantly, the Supreme Court has held that disputes implicating public rights can be adjudicated without jury trials. For example, in *Thomas v. Union Carbide Agricultural Prod. Co.*, 473 U.S. 568 (1985), the Supreme Court rejected Union Carbide's right to sue for violations of trade secrets, and upheld Congress' establishment of an administrative process for registering pesticides as part of a comprehensive re-working of federal pesticide law. By this rationale, an administrative approach to resolving malpractice disputes should be constitutional if health courts are created as part of a comprehensive regulatory scheme for reforming the health care system. See, for example, *New York Central RR v. White*, 243 U.S. 188 (1917).

²⁸ *Colaio v. Feinberg*, 262 F. Supp. 2d 273 (S.D.N.Y. 2003), *aff'd* *Schneider v. Feinberg*, 345 F.3d 135 (2d Cir. 2003).

²⁹ Among these experts and academics are Peggy O'Kane, President of National Committee on Quality Assurance; Ken Kizer, former President of the National Quality Forum; Helen Darling, President of the National Business Group on Health; Troyen Brennan, former President of the Brigham & Women's Hospital in Boston and Professor at the Harvard School of Public Health; and William Brody, President of Johns Hopkins University. More information can be found at <http://cgood.org/brochure-hcare.html>.

³⁰ *Health Courts offer cure*, USA Today, July 4, 2005, Editorials/Opinion.

³¹ *Scalpel, Scissors, Lawyer*, The Economist, December 14, 2005, Opinion.

³² *It's Time to Try Special Health Courts*, The New York Times, January 9, 2005, Editorial.

³³ H.R. 1546, 109th Congress, 1st Sess. (2005).

³⁴ S. 1337, 109th Congress, 1st Sess. (2005).