

Responses and Solutions to the Crisis

Few physicians are unaffected by the medical malpractice crisis. Even those who have not been hit with a lawsuit may have changed the way they practice or may have gotten involved in efforts to solve the problem.

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Many have joined the fight for more comprehensive solutions. Physicians in Pennsylvania and North Carolina, for example, have set up innovative organizations to help their colleagues respond effectively to frivolous

malpractice claims that lack evidence of injury or substandard care. The American Medical Association and other physicians' organizations continue to push for legislative measures that would limit awards in malpractice cases. The Robert Wood Johnson Foundation and other organizations are exploring alternative dispute-resolution models such as mediation and special courts just for dealing with malpractice cases. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and

other groups are pushing for reforms—including practice guidelines—that standardize care, reduce risk of errors, and increase patient safety.

Defensive Medicine

In response to the medical malpractice crisis, many doctors are resorting to *defensive medicine*, ordering more tests and making more referrals than medically indicated. The American Medical Association (AMA) says that

In the big picture, the risks of defensive medicine outweigh benefits. Each time a patient undergoes a procedure, there is a risk—however slight—of harm or error. The risks to the health-care system as a whole are much greater: defensive medicine can both increase the cost of medical care and decrease access to services due to a greater demand for those services.

defensive medicine can take many forms, including referring patients to specialists and declining to accept elective referrals from emergency departments. This trend may be more prevalent among high-risk specialists who are likely to pay higher liability insurance premiums. Defensive medicine is estimated to cost at least \$60 billion a year, according to the Department of Health and Human Services.

Most defensive medicine offers at least some medical benefit—those extra tests may actually reveal a condition that might otherwise have gone undiagnosed. But in the big picture, risks outweigh benefits. Each time a patient undergoes a procedure, there is a risk—however slight—of harm or error. The risks to the health-care system as a whole are much greater: defensive medicine can both increase the cost of medical care and decrease access to services due to a greater demand for those services, says an article on defensive medicine in the December 2005 issue of the newsletter *Joint Commission Perspectives on Patient Safety*.

A recent study published by the *Journal of the American Medical Association (JAMA)* in June 2005 uncovered widespread use of defensive medicine by physicians. David Studdert, LLB, ScD, MPH, and colleagues at the Harvard School of Public Health conducted a survey of physicians who were paying the highest malpractice premiums in Pennsylvania. The survey found that of the 824 respondents (including specialists in such high-risk

fields as obstetrics/gynecology, surgery, radiology, emergency medicine, and orthopedic surgery), 93 percent reported that they practiced defensive medicine, which included ordering additional tests or treatment or refusing to treat the patient at all. Of the physicians who reported practicing defensive medicine, 43 percent reported using imaging technology in clinically unnecessary circumstances. Forty percent reported that they had taken steps to restrict their practice in the previous three years, including eliminating procedures prone to complications, such as trauma surgery, and avoiding treating patients who had complex medical problems or who were perceived as litigious.

The authors concluded that defensive medicine is highly prevalent among physicians in Pennsylvania who pay the most for liability insurance, and cautioned that this finding has serious implications for the delivery of healthcare.

Going Without Insurance

While uncommon, some physicians have gone in the opposite direction from defensive medicine. Instead of avoiding risk by changing the way they practice, and instead of paying insurance companies to cover malpractice claims, they are assuming risk to practice medicine in their own areas without insurance coverage. This is only possible in some states, but in a few areas, such as Florida, it is gaining popularity.

Going bare, however, presents its own set of problems, says Donald L. DeMuth, a professional management consultant in Harrisburg, Pa. There are professional liability cases that do have merit, and physicians don't want to be subject to one of those without insurance coverage, he warns. Doctors without liability coverage put their personal assets at stake.

They also limit their practice options. A number of states, including Pennsylvania and Connecticut, for example, require physicians to carry liability insurance if they intend to practice medicine in those states. In addition, most hospitals require physicians to carry professional liability coverage. Health plans generally include standard contract clauses that require a certain minimum amount of malpractice coverage for their network physicians. Group practices also commonly require their doctors to maintain a certain amount of coverage, whether it is purchased

individually or through the group.

In Florida, however, where insurance premiums have reached an all-time high, going bare has gained some recent converts. The National Center for Policy Analysis reported that more than 5 percent of Florida's roughly 47,700 active medical doctors lack malpractice insurance coverage. In Miami-Dade County, nearly 20 percent of the county's 6,360 active medical doctors are without liability insurance.

While self-insuring can save money on administrative costs, physicians must understand that they are assuming greater financial responsibility for malpractice claims than they would if they had insurance coverage. Physicians who go bare face a potential loss of their own personal assets (such as their house, car, and investments) in paying off a plaintiff and paying an attorney.

In response to this situation, many hospitals across Florida have granted admitting and staff privileges to physicians without insurance as long as they meet other requirements. Doctors who choose this option are responsible for up to \$250,000 of an judgment, and must inform all their patients that they are uninsured. In addition to the hospital policies, the state of Florida has put other regulations into place for physicians practicing without insurance. For example, these

physicians must prove that they have \$250,000 in available assets in case there is a claim brought against them.

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Another disadvantage to going bare is the added risk to colleagues. Since a plaintiff's lawyers are going after the largest possible award, they tend to direct their energy where they think they can get it—and that means focusing on the insured physician. Even if a physician is completely innocent of negligence, the patient's attorney may work hard to establish that he or she is

someone responsible since he or she was in a shared practice with an uninsured doctor. Most lawyers will advise physician clients not to work with a doctor who lacks liability insurance.

Physicians who practice without insurance are putting not only themselves and their colleagues at risk, but their patients as well. If there is an instance in which actual malpractice has occurred, then the patient suffers if the doctor cannot afford to pay the appropriate reward.

Physicians who decide to self-insure are advised to take special steps to protect personal assets by talking to an estate-planning attorney with expertise in asset protection. Such protection strategies should be put in place well before a liability occurs. In Florida, doctors practicing without insurance are permitted to protect certain specific assets, such as retirement plans, annuities, and life insurance.

For physicians who do choose to go bare, it is important to inform patients, payers, and the regulators in their states. Legal and insurance experts maintain that going bare should be only a last resort when insurance is not available or affordable and all available options have been explored.

Waivers and Arbitration Agreements

Another approach that some physicians are taking is to ask all their patients to sign waivers, which state that the patient will never sue for frivolous reasons. This strategy conceivably can work in some cases. However, such an approach is unlikely to be viable in a number of jurisdictions, says Mark Langdon, an attorney with the Washington, D.C., law firm of Arent Fox. To find out whether such a waiver would be enforceable in your state, consult your attorney.

Some physicians are urging patients to sign *arbitration agreements*, in which patients agree to resolve medical malpractice disputes without a formal lawsuit. Supporters of these agreements say that arbitration is less expensive for both patients and physicians than a court trial, and negligence claims are settled faster by this route than by going through the court system. Some legal experts maintain that the use of voluntary alternative dispute resolution techniques is an option that should receive more attention in dealing with the medical malpractice crisis in the nation.

In states such as California and Utah, arbitration is becoming a popular alternative to malpractice lawsuits. When entering into binding arbitration, both parties must accept the decision of the arbitrator. In most cases, the arbitrator is either a retired judge or a practicing attorney. When patients and physicians sign the arbitration agreement, they waive their right to a jury trial, and the arbitrator acts as both judge and jury.

Dr. Wheeler believes that the arbitration process is an economic, efficient, confidential, and neutral way to reach a resolution when a dispute exists about medical care. Those who support arbitration say that it helps eliminate the majority of trivial lawsuits, while properly awarding truly injured patients.

Before arbitration begins, each party in the case selects its own arbitrator, and these two will then select a third, neutral arbitrator. These three arbitrators hear the case.

Dr. Catherine J. Wheeler, an Ob/Gyn specialist in Salt Lake City, Utah, has been asking her patients to sign agreements that specify that all malpractice disputes

will be settled through arbitration. Although she has not been involved in an arbitration herself, Dr. Wheeler believes that the arbitration process is an economic, efficient, confidential, and neutral way to reach a resolution when a dispute exists about medical care. Those who support arbitration say that it helps eliminate the majority of trivial lawsuits, while properly awarding truly injured patients.

The arbitration process also saves time. Most medical malpractice lawsuits span months and often years, while arbitration usually lasts only three to five days. In addition, arbitration allows participants to avoid crowded court dockets and to schedule their meeting when they are most convenient for all parties.

Dr. Wheeler says that most of her patients are very positive about signing an arbitration agreement. Dr. Wheeler tells her patients that if she makes a mistake, she wants to be able to talk to them about it. They feel more comfortable just because I have taken the time to say to them that I really care what happens to them, she explains. If an error occurs and they can't reach an agreement, arbitration is a way to resolve it faster, she maintains.

Voluntary arbitration agreements may have had an effect on malpractice insurance rates. For example, the Utah Medical

Insurance Association, a non-profit self-insurance company, announced that medical malpractice insurance premiums would not increase in 2006, after a steady period of annual rate hikes. The company attributed this leveling off to the fact that arbitration had decreased the cost of defending claims.

In California, Kaiser Permanente, one of the state's major insurance companies, uses arbitration to settle all legal claims. The company, which has utilized arbitration since 1971, informs its members that arbitration is the required method to resolve all disputes. Within the Kaiser plan, members are qualified to receive punitive damages, and since there is no cap on an arbitration award the arbitrator can award an amount of damages that he or she chooses. The majority of legal disputes in Kaiser's program are resolved within 11 months.

While there are many supporters of the arbitration process, there are critics as well. Some attorneys feel that relinquishing a patient's constitutional right to a trial is inappropriate. They also point out that if the arbitration process fails, the dispute will then end up in court, increasing the cost and loss of time for both the patient and the physician.

An arbitration agreement must be written and completed properly in order to be effective. Missing information such as dates and the name of the physician group as well as the names of its individual physicians is a common mistake. If the patient is a minor, his or her adult legal representative must sign and date the agreement.

Arbitration is not without costs. The two parties in a dispute must pay the cost of their arbitrator and usually split the cost for the third, neutral arbitrator as well. Some arbitrators charge the patient only a contingency fee, meaning that the arbitrator collects a fee only if the patient recovers money. Others charge an hourly rate, which generally ranges from \$100 to over \$300 an hour. Patients are also responsible for covering the costs associated with calling expert witnesses to testify.

Voluntary Mediation

Another alternative model is voluntary mediation. Under this alternative dispute strategy, the two parties work together with the help of a trained neutral mediator, or facilitator, to

resolve the dispute. In Pennsylvania, a demonstration project sponsored by the Pechar Charitable Trust encourages mediated dispute resolution. According to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) report entitled *Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury*, in this model, physicians are encouraged to disclose adverse events to their patients and to apologize. Patients or their families are provided with an early and fair offer of compensation, and the opportunity for mediation to resolve disputes. According to the report, early indications are that it has been successful in mitigating litigation.

One mediation program that has been in place since 1995 is the Rush Mediation Program at the Rush-Presbyterian-St. Luke's Medical Center in Chicago. This program uses neutral third-party mediators to help the two sides reach a voluntary settlement of their differences. In Rush's program, the plaintiff's counsel is invited to select either a retired judge or two attorney mediators. Each party exchanges pre-conference submissions, including a statement of the facts, description of the injury, special damages, and past and future expenses.

The parties then select a neutral location for the mediation to

Learning the 3 R's

Physicians insured by the COPIC Insurance Company are learning about a different three R's. Instead of reading, 'riting, and 'rithmetic, these doctors are learning to recognize, respond, and resolve unanticipated medical outcomes.

According to the physician-owned liability insurer that provides malpractice coverage to physicians in Colorado and Nebraska, the initiative has already proven successful. Company statistics indicate that since October 2000, the program has handled 2,578 incidents that might otherwise have ended up in a court case. (As of June 2006, only 54 incidents had become formal claims, and none of them have ended up in court.) Approximately 2,650 COPIC-insured physicians currently participate in the program.

The COPIC program is designed to assist patients who have experienced an unanticipated medical outcome by facilitating early, candid communication between physician and patient. The program helps the

take place. Each has a chance to present its case, which is then followed by a breakout session in which the mediators meet individually with each party. Finally, the two parties reconvene to conclude the negotiations. Statistics indicate that the program has successfully resolved more than 80 percent of filed claims.

Hitting Back With Countersuits

Some physicians are attempting to deal with the crisis by using the threat of countersuits to put an end to frivolous lawsuits from over-eager attorneys. In this strategy, a physician brings a countersuit that alleges that the malpractice suit lacks merit and that the individuals involved are abusing the legal process. If a physician files such a countersuit, he or she can claim compensation from and punishment of the countersuit defendants.

Physicians may be able to recover compensatory monetary damages for the practice time and income that were lost while defending a frivolous lawsuit. In one recent case, Dr. Frank Bonnarens, an orthopedic surgeon in Louisville, Ky., won his countersuit against the plaintiff's attorney and collected \$450,000, including \$200,000 in punitive damages. The judgment is the second in six years to be returned against a plaintiff's

physician by making sure that he or she responds in a timely fashion to a poor outcome—and helping to avoid a malpractice claim. It also assists physicians to communicate with the patient in an empathetic manner and to arrange for additional care or services that the patient may need as a result of the outcome.

Under the program, patients can receive compensation for their loss of time at \$100 a day (capped at \$5,000) and reimbursement for out-of-pocket expenses related to the unanticipated outcome (capped at \$25,000). In addition, patients retain their right to pursue legal action. However, if the patient submits a written demand for compensation or pursues legal recourse, he or she is no longer eligible for further program benefits.

Since its inception in October 2000 through August 2006, approximately 661 patients have been reimbursed. The total amount of patient reimbursement has reached nearly \$3.6 million or \$5,488 per paid incident.

lawyer in the state of Kentucky.

To help physicians with countersuits, two organizations have been launched to stop frivolous suits in their tracks. Started in August 2005, Doctor's Advocate (www.doctorsadvocate.org), offers an inexpensive legal service designed to terminate frivolous suits.

In the Doctor's Advocate program, participating physicians who are sued provide a copy of the complaint to a Doctor's Advocate lawyer, who analyzes the facts in the case. If the lawsuit appears frivolous, the attorney applies pressure on the plaintiff's attorney to terminate the lawsuit with the threat of a countersuit.

Expensive judicial awards on behalf of some patients embolden individuals and their attorneys to take a chance on suing the doctor, even when the case may lack merit. Physicians are vulnerable to frivolous lawsuits because plaintiffs and their lawyers believe they have nothing to lose by suing a doctor, says Dr. Elliot Menko, MD, an orthopedic surgeon and one of the co-

founders of the Pottstown, Pa.-based organization.

In the Doctor's Advocate program, participating physicians who are sued provide a copy of the complaint to a Doctor's Advocate lawyer, who analyzes the facts in the case. If the lawsuit appears frivolous, the attorney applies pressure on the plaintiff's attorney to terminate the lawsuit by threatening to bring a countersuit.

Doctors need someone they can trust to turn to if they are hit with a frivolous suit, says Dr. Menko, MD. The Doctor's Advocate attorney works in conjunction with the attorney appointed by the physician's insurance company. However, Dr. Menko, MD cautions that if a situation occurs that is clearly a case of malpractice, Doctor's Advocate will not attempt to get physicians out of this responsibility. The patient should be compensated if the doctor really made a mistake, he says.

If litigation ensues after initial contact, and the doctor is found not to be at fault, the Doctor's Advocate attorney may file a countersuit on a contingency basis, seeking professional disciplinary action against the plaintiff's attorney and medical expert witnesses. A countersuit can take place once the original lawsuit has run its course.

The fee to join Doctor's Advocate is \$1,200 per year. If a doctor has a medical malpractice lawsuit pending, there is an additional one-time flat fee of \$5,000. (Dr. Menko insists that this amount is usually less than a physician would pay to hire a private attorney.)

Dr. L. L. Costlett-Charlton, an OB/GYN specialist from Wilkes-Barre, Pa., offers a Doctor's Advocate success story. Her case involved a patient with whom she had met late in the patient's pregnancy, for the first and only time. After an examination revealed serious complications, she sent the patient to a hospital, and doctors at the hospital took over treatment. The patient later sued several doctors, including Dr. Costlett-Charlton, for malpractice. After reviewing the lawsuit, Doctor's Advocate demanded that the plaintiff's attorney drop the suit against Dr. Costlett-Charlton, under threat of a countersuit.

The case, which had already dragged on for over one year, was dropped approximately seven weeks after Doctor's Advocate became involved. We are leveling the playing field and giving doctors an opportunity to have personal counsel at a reasonable rate, says Robert B. Surrick, Esq., co-founder and executive director of Doctor's Advocate.

Another organization, Medical Justice Services (www.medicaljustice.com), based in Greensboro, N.C., provides a similar service. Medical Justice Services (MJS), launched in 2002, provides coverage to physicians in more than 35 states.

When a claim is made against an MJS member physician, the company activates an early-intervention strategy in which its defense counsel notifies the plaintiff's counsel that the physician has the legal and financial resources to fight frivolous claims. Previous experience has shown that this notification alone can be enough to persuade the plaintiff to drop a meritless case.

If the early intervention does not work, the company's attorneys may prosecute counterclaims. At the conclusion of a case in which the physician is found to be not at fault, plan members in the same specialty or the MJS legal team may review the case to determine whether the case or testimony was indeed frivolous. If it is determined that the case was frivolous, a counterclaim is devised to obtain redress against the proponents of the suit, including physicians who served as expert witnesses. In some

cases, witnesses have been disciplined or suspended. The organization maintains that this approach can help decrease the number of frivolous lawsuits experienced by physicians.

Depending upon a physician's specialty, the annual fee to join MJS ranges from \$625 to \$1,800, and additional retroactive coverage can be purchased for a one-time fee of \$1,400 to \$4,000. Members agree to review one case per year and to require all their patients to sign a contract that prohibits them from filing frivolous lawsuits and obligates them to settle legitimate disputes through board-certified experts.

Seeking Legislative Reforms

Another area that physicians are fighting back is by joining the efforts of the AMA and other associations that are actively urging state and federal legislatures to enact medical malpractice reform measures. Since malpractice is a *tort* (defined as a civil wrong that happens outside of a formal agreement), the AMA and other physicians groups are calling for *tort reform*.

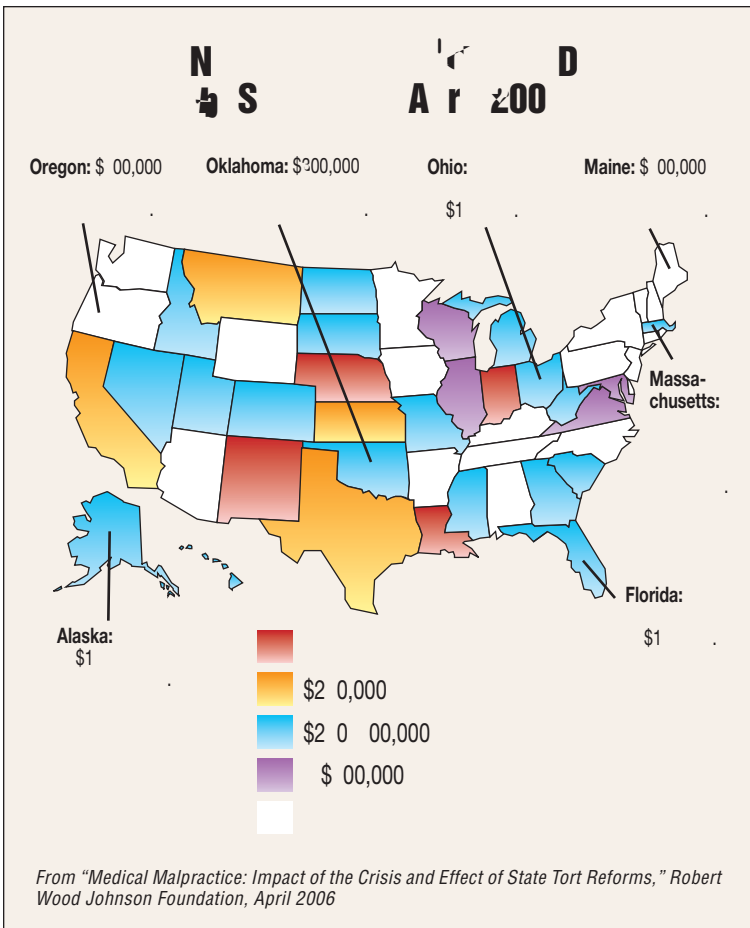
Congress has considered legislation to reform the existing medical malpractice system several times over the last five years. The federal legislation would place a \$250,000 cap on non-economic damages (pain and suffering), a cap that limits the amount of money a plaintiff can receive as an award in a lawsuit. The measure passed in the House, and the AMA urged its members to lobby Senators to support this legislative effort. Unfortunately, the Senate recently failed again to pass this reform measure.

Groups representing physicians have had more success with legislative efforts at the state level. The Insurance Information Institute says that 25 states have passed legislation that caps medical malpractice non-economic damage awards. These caps help reduce the average medical malpractice award by 20 to 30 percent, according to the Robert Wood Johnson Foundation report on medical malpractice and tort reform. Preliminary research shows that damage caps reduce average awards and modestly constrain premiums. In states where damage caps have been established, there has also been a small increase in physician supply because the more favorable malpractice climate attracts physicians to set up practices or take jobs in these states. But the report also noted that damage caps disproportionately

affect compensation for the most severely injured patients, which raises equity issues.

California's Medical Injury Compensation Reform Act (MICRA), which became effective in 1976, is considered a model for other states and the federal government to emulate. It places a \$250,000 limit on non-economic damages on a per-incident basis, limits contingency fees to attorneys, and allows periodic payment of future damages, among other provisions.

Under MICRA, injured patients receive full compensation for



all quantifiable damages, such as lost income, medical expenses, and long-term care. Between 1976 and 2004, medical liability insurance premiums throughout the rest of the country have increased more than three times faster than premiums in California, Dr. Cecil B. Wilson, an AMA board member, recently pointed out. The AMA estimates that MICRA saves more than \$1 billion per year in liability premiums.

Texas has succeeded with Proposition 12, a landmark tort reform law capping pain-and-suffering awards in medical malpractice cases at \$750,000. Patients can still be fully compensated for all economic damages. Experts maintain that this legislative effort has helped to stabilize the Texas medical malpractice marketplace and benefited both physicians and patients.

In more recent action, a new law enacted in Wisconsin caps non-economic damage awards at \$750,000, after the state Supreme Court struck down an earlier cap that it found to be arbitrary and unconstitutional. Georgia, Illinois, and South Carolina have similar laws that cap medical malpractice non-economic damage awards.

Other Reform Measures

Another reform that has been suggested to address the current crisis is to create a more patient-centered injury-compensation system that helps patients get the money they need when an

What Works?

As states continue to grapple with the medical-malpractice crisis, a research report from the Robert Wood Johnson Foundation entitled "Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms" finds that caps on noneconomic damages reduce the average size of awards by 20 to 30 percent. In addition, caps on non-economic damages have a slight impact on premium growth. The study found that other types of tort-reform measures have had little impact. Joint-and-several liability reforms, which limit each defendant's liability according to their involvement in the incident, constrain the growth of premiums, but have no significant effect on claims payouts or physician supply.

unanticipated outcome occurs. A restructuring of the current system should be designed to reduce litigation by preventing patient injury, according to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) report.

The JCAHO report says that this can be accomplished by encouraging open communication and disclosure among patients and providers, and by assuring prompt and fair compensation when safety systems fail. The report also recommends that Congress assist in creating a predictable and fair compensation system by providing funding for pilot projects through the Department of Health and Human Services.

Healthcare experts believe that more should be done to encourage adherence to clinical guidelines and other desired performance in order to reduce liability claims. For example, if guidelines say that no X-rays are necessary for certain conditions, the physician can elect not to order the test with some degree of confidence. Many guidelines are available in software programs that can be downloaded to a personal digital assistant.

Adherence to practice guidelines is an effective way, not only to improve quality and reduce variation in care, but to reduce legal risk, Dr. Dennis O'Leary, JCAHO's president, told the Senate Energy and Commerce Subcommittee on Health. He cited a new study undertaken by Scott R. Ransom and David M. Studdert, which found a six-fold increase in risk litigation for obstetrical patients when there was a deviation from relevant clinical guidelines. The research also found that one-third of all obstetrical claims analyzed were linked to care that did not adhere to guidelines.

Testifying before the Senate panel, Mr. Studdert outlined the specific reforms that he believes are needed to deal with the crisis. They include the following:

- Making compensation more accessible to patients who sustain preventable injuries
- Speeding up the process of determining eligibility for compensation
- Making compensation decisions more accurate and reliable (ideally through incorporation of the best available clinical evidence into decision making)
- Making assessments of damages more accurate and reliable

- Making the system less threatening to doctors and encouraging transparency about errors

Exploring the Possibility of Health Courts

Some legal experts believe that setting up special courts to settle malpractice disputes could be a better way to address today's crisis. The concept of *health courts* has a number of elements, including these:

- Use of trained judges relying on neutral experts to settle malpractice disputes
- Reliance on a different standard of liability, known as *avoidability*
- Explicit use of evidence-based guidelines in decision making
- Schedules for compensation that injured claimants receive

Under this approach, health-court judges could have expertise in medical issues and could be selected through an independent, nonpartisan screening process. Judges could participate in additional training and education to remain current in their understanding of evolving healthcare issues.

Compensation decisions in a health-court system could not be based on a standard of negligence, but on *avoidability*, which is considered by those who support health courts to be a broader concept than negligence. Under *avoidability*, 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 itself was negligent.

Some legal experts believe that today's negligence standard contributes to an overemphasis on blaming providers for adverse events that have occurred in treatment. However, studies show that most errors result, not from individual malfeasance, but rather from breakdowns in systems of care, says Paul J. Barringer, III, General Counsel of Common Good (cgood.org), a legal reform coalition that advocates the creation of health courts. Mr. Barringer testified about this approach before the House Energy and Commerce Subcommittee on Health. Application of the *avoidability* standard should help lessen the emphasis on blaming individual providers, Mr. Barringer told the House panel. 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, he explained.

Common Good's largest financial supporter is the Robert Wood Johnson Foundation, which is currently participating in a two-year collaborative effort between Common Good and the Harvard

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School of Public Health to do the research and consensus-building believed to be necessary for the health-court concept to be successfully adapted and accepted in the U.S. Researchers will analyze how medical-injury cases are handled in health courts already in place in countries such as Sweden and New Zealand. A new system for the U.S. would require definitions for a host of issues, such as the range of covered injuries and the qualifications of judges and expert witnesses. Supporters of the health-

court concept say that health courts follow precedents already established by special courts that exist in the U.S. for tort, bankruptcy, and family disputes.

Another advantage of health courts is how they handle expert witnesses. Mr. Barringer maintains that under the existing system, these competing experts-for-hire provide distorted or conflicting advice that can confuse juries and add time and expense to the process by which disputes are resolved. But under a health-court system, judges could consult with neutral medical experts to determine the standard of care in medical-injury cases. Expert witnesses in a health-court setting could be compensated by the court, and they could be held accountable to a standard of objectivity by regulator authorities. To help health-court judges in reaching consistent decisions from case to case, judges could consult clinical-practice guidelines based on evidence-based practice standards, such as those published by the National Guidelines Clearinghouse at the U.S. Agency for Healthcare Research and Quality, or by medical-

special organizations.

To promote better equity for patients, the health-court system could 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, Mr. Barringer explained. As a result, individual awards could be smaller on average than the awards in the current system, but having compensation schedules could ensure that more plaintiffs had access to reasonable compensation. Supporters of health courts believe that the use of a compensation schedule could help reduce the percentage of total system costs devoted to administrative expenses.

Several hospitals and academic medical centers have announced their strong interest in serving as pilot projects for the health-court concept. They include Duke University School of Medicine and Health System, Emory Healthcare, Jackson Health System/University of Miami Leonard M. Miller School of Medicine, Johns Hopkins Medicine, New York-Presbyterian, and Yale-New Haven Hospital. In addition, several leaders in patient safety and health care are calling for a special health-court pilot project. They include JCAHO president Dr. O'Leary and Martin J. Hatlie, Esq., president of the Partnership for Patient Safety.

In addition, several bills have been introduced in Congress to create health-court pilot projects. A Senate bill would facilitate state-level experimentation with a number of alternatives to current medical-malpractice litigation, including health courts, early-offer programs, and scheduled compensation. Legislation to create or to explore the feasibility of creating health courts also has been introduced in a number of states, including, Illinois, Maryland, New Jersey, Pennsylvania, and Virginia.

During hearings on the Senate bill, Dr. Studdert, associate professor of law and public health at the Harvard School of Public Health, told the Senate health panel that patients in the U.S. could benefit from improvements in the way the legal system handles medical injuries. He voiced support for a more efficient system for determining eligibility for compensation so that money currently absorbed by administrative costs could be redirected toward compensation. Research conducted at the Harvard

School of Public Health found that 80 percent of administrative costs are absorbed in resolving claims that involved harmful errors. Alternative approaches to compensating medical injuries, such as the health-court model, have the potential to improve performance and provide patients

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with a better system for compensating medical injuries, he said.

But critics of the health-court concept are expressing concerns. They maintain that patients should not be required to give up their rights to a jury trial. Joanne Dorosho, executive director of the Center for Justice & Democracy, told the House panel that there is nothing wrong with alternative dispute resolution or alternative compensation systems, provided they are truly voluntary and do not eliminate the right to trial by jury. She told

the panel that a majority of states will find health courts unconstitutional based on their state constitutional provisions safeguarding the right to a jury, the right to open access to the courts, and/or the right to due process.

Concerns are also expressed about the compensation arrangement if health courts were established. Cheryl Niro, a member of the House of Delegates of the American Bar Association, said that a schedule for the assessment of damages is not appropriate in medical-malpractice cases in which a fixed, rigid assessment would treat all patients with similar injuries the same.

Despite all the approaches outlined to deal with medical-malpractice problems, experts say that unless fundamental reforms are put in place to fix the existing system, today's crisis is not likely to abate anytime soon.