

A New Prescription for America's Medical Liability System

Paul J. Barringer III

Follow this and additional works at: <http://digitalcommons.law.umaryland.edu/jhclp>



Part of the [Courts Commons](#), and the [Health Law Commons](#)

Recommended Citation

Paul J. Barringer III, *A New Prescription for America's Medical Liability System*, 9 J. Health Care L. & Pol'y 235 (2006).
Available at: <http://digitalcommons.law.umaryland.edu/jhclp/vol9/iss2/3>

This Conference is brought to you for free and open access by DigitalCommons@UM Carey Law. It has been accepted for inclusion in Journal of Health Care Law and Policy by an authorized administrator of DigitalCommons@UM Carey Law. For more information, please contact smccarty@law.umaryland.edu.

A NEW PRESCRIPTION FOR AMERICA'S MEDICAL LIABILITY SYSTEM

PAUL J. BARRINGER, III*

INTRODUCTION

The debate over medical malpractice reform consistently remains one of the most polarized in American politics. For years, Republicans have aggressively sought to implement a number of tort reforms to limit malpractice lawsuits and damages, including the creation of a federal cap on payments for non-economic damages in malpractice cases. At the same time, Democrats have vociferously decried such measures as favoring only the medical establishment and insurance companies, and as riding roughshod over the rights of injured patients. Each side buttresses its arguments with copious (and partisan) studies and statistics.

Frequently lost in the talking points and partisan bickering 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 choose to file a claim. Even fewer receive any compensation, and those who do will see their awards significantly reduced. When attorneys' fees and other administrative costs are included, only forty-six cents of every dollar spent in tort cases in 2003 reached injured claimants.¹

The system also fails health care providers. While litigation does place a substantial burden on physicians, this is only part of the story. In particular, today's system does a poor job of 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

* Paul Barringer is general counsel to Common Good, a national non-profit advocacy organization in Washington, D.C. The author wishes to thank Michael S. Henry for his invaluable assistance in preparing this article.

1. TILLINGHAST-TOWERS PERRIN, U.S. TORT COSTS: 2003 UPDATE 17 (2003), *available at* http://www.towersperrin.com/TILLINGHAST/publications/reports/2003_Tort_Costs_Update/Tort_Costs_Trends_2003_Update.pdf.

2. Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q. J. ECON. 353, 353-54 (1996). It is important to note that there are substantial variances in estimates of what defensive medicine costs the U.S. health care system. Kessler and McClellan present perhaps the highest estimate, although the validity of this estimate has been challenged. *See id.* at 386 (reporting that reforms directly limiting doctor and hospital liability reduce hospital expenditures between 5% and 9% within five years). There is little question, however, that defensive medicine does in fact occur. *See also* David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 JAMA 2609, 2609-17 (2005) (noting the widespread domestic and foreign reports of defensive medicine).

misses.”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

Notwithstanding these failings—and the persistently polarized political climate—support today is growing for a new approach to resolving medical injury disputes: the creation of administrative “health courts.” Health courts would feature trained judges—with expertise in health care—who would adjudicate malpractice cases. These health court judges, not juries, would make decisions about the standard of care, relying on neutral outside experts. When compensation is awarded, patients would receive economic and non-economic damages pursuant to a schedule of benefits relating to patient circumstances and severity of injury. The system would rely more on administrative processes, and would be explicitly linked to patient safety structures to ensure reporting of information about errors and near misses in treatment.

The concept of resolving particular disputes through specialized court systems is nothing new to American law. Since the Judiciary Act of 1789, for example, admiralty courts have—without juries—handled disputes arising from navigation, ocean resources, and maritime commerce.⁵ Domestically there are special courts and/or administrative compensation processes for workers’ compensation, tax law, patent law, vaccine liability, and other areas, and overseas there are strong precedents for administrative approaches to resolving medical injury disputes.⁶

The national advocacy organization Common Good (to which the author is general counsel) is currently working with the Harvard School of Public Health on a Robert-Wood-Johnson-Foundation-supported project to refine the health courts proposal and to assemble a broad coalition of stakeholders from across the political spectrum in favor of developing pilot projects to test the new approach. To date,

3. See COMM. ON QUALITY HEALTH CARE IN AM., INST. OF MED., *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* 218-219 (2001) (reporting reluctance among doctors to report adverse events for fear of liability).

4. See *id.*; JOINT COMM’N ON THE ACCREDITATION OF HEALTHCARE ORGS., *HEALTH CARE AT THE CROSSROADS: STRATEGIES FOR IMPROVING THE MEDICAL LIABILITY SYSTEM AND PREVENTING PATIENT INJURY* 27 (2005) [hereinafter JOINT COMM’N], http://www.jcaho.org/news+room/health+care+issues/medical_liability.pdf (“An unintentional consequence of the tort system is that it inspires suppression of the very information necessary to build safer systems of health care delivery.”).

5. FED. R. CIV. P. 38(e) (excluding admiralty claims from right to jury trial); see NICHOLAS J. HEALY & DAVID J. SHARPE, *CASES AND MATERIALS ON ADMIRALTY* 6-7 (2d ed. 1986) (providing an overview of the evolution of admiralty courts).

6. See David M. Studdert et al., *Can the United States Afford a “No-Fault” System of Compensation for Medical Injury?*, 60 *LAW & CONTEMP. PROBS.* 1, 10-15 (1997) [hereinafter *Can the United States Afford a “No-Fault” System?*] (discussing no fault medical injury compensation systems in Sweden and New Zealand).

the proposal has drawn support from a wide array of stakeholders, including patient safety advocates, consumer groups, public health and legal experts, national publications, and health care provider groups. The following analysis outlines the context within which this proposal has arisen, the fundamental elements of the evolving new concept, and the growing coalition of supporters.

I. PAST MALPRACTICE CRISES: A BRIEF HISTORY

The medical malpractice system has been much in the news in recent years, but it has not through recent decades been a health policy issue to generate the consistent interest of, say, the uninsured or rising costs. Indeed, Professor William Sage, formerly of Columbia University Law School, has referred to medical malpractice as the “Rip Van Winkle of health policy” because of the way it has tended to fade periodically from prominence and then reappear at certain intervals.⁷

There have in fact been several crises in medical malpractice since the 1970s, with the first occurring in the middle of the decade. In part due to broader societal shifts that encouraged consumers to challenge authority to a greater extent, the late 1960s and early 1970s witnessed a significant increase in malpractice litigation against physicians.⁸ Coupled with economic difficulties triggered by the OPEC oil embargo, many of the commercial insurance companies that had provided malpractice insurance policies to physicians withdrew from the market.⁹ This left a large number of physicians without coverage. In response to this “crisis of availability,” physicians engaged in substantial political outreach, which helped to secure the passage of favorable legal reforms in state capitols around the country. Perhaps most notable in this regard was California’s Medical Injury Compensation Reform Act (MICRA), a law which, among its other provisions, limited non-economic damages in malpractice cases to \$250,000 (almost \$910,000 in 2005 dollars¹⁰). Physicians in many states also contributed their own capital to support efforts by their state medical associations, hospital associations, and others to create mutual, i.e., physician-owned, malpractice insurance companies.¹¹ As many

7. Posting of Bill Sage to <http://www.pointoflaw.com/feature/> (Nov. 14, 2005, 10:18 AM EST).

8. See, e.g., Lisa T. Meeks, *Ohio Blows the Lid Off the Medical Malpractice Damage Cap: Morris v. Savoy*, 20 N. KY. L. REV. 569, 569-74 (1993) (describing the perceived medical malpractice crisis in the 1960s and 1970s).

9. See Glen O. Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, 49 LAW & CONTEMP. PROBS. 5, 6 (1986).

10. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, INFLATION CALCULATOR, <http://data.bls.gov/cgi-bin/cpicalc.pl> (last visited Sept. 21, 2006) (finding that \$250,000.00 in 1975 has the same buying power as \$907,528 in 2005); 1975 Cal. Stat. page no. 3949, 3969 (codified as amended at CAL. CIV. CODE § 3333.2 (West 1997 & Supp. 2006)).

11. See William M. Sage, *The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis*, 23 HEALTH AFF. 10, 12 (2004) [hereinafter *The Forgotten Third*] (discussing how state medical societies filled in the gaps of private liability insurance by chartering mutual carriers).

as one hundred of these so-called “bedpan mutuals” were started across the country.¹² These physician-owned insurance companies remain today the most important source of malpractice insurance coverage for physicians (insuring about 60% of U.S. physicians in private practice).¹³

About ten years later, the second medical malpractice crisis occurred. The primary characteristic of this “crisis of affordability” was a substantial increase in the cost of malpractice insurance premiums, associated with increased claiming and a difficult investment climate for insurers. Physicians essentially resolved this crisis by passing along their increased malpractice premium costs in the reimbursement rates they charged to public and private payors.¹⁴ Also during this period, most insurers shifted away from selling “occurrence” policies (which cover claims arising from events during the time the policy is in effect) and toward providing “claims made” policies (which cover claims reported during the time the policy is in effect).¹⁵

The third medical malpractice crisis began in the late 1990s, and continues today. Malpractice insurance rates have increased dramatically in recent years, particularly for certain specialties including obstetrics and emergency medicine. There is evidence (disputed by some consumer advocates) that claims frequency and severity have increased, and that the size of both average and the largest payouts have risen substantially.¹⁶ At the same time, many malpractice insurers have experienced financial difficulties, due to low interest rates (about 80% of the typical malpractice carrier’s investment portfolio is invested in high-grade bonds¹⁷) and a difficult reinsurance climate after the September 11th terrorist attacks. Moreover, competition in the malpractice insurance market in the 1990s contributed to some carriers’ offering policies that did not fully cover the costs of

12. *Harming Patient Access to Care: The Impact of Excessive Legislation: Hearing Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 107th Cong. 87 (2002) (statement of Richard Anderson, CEO, Doctor’s Co.).

13. *Patient Access Crisis: The Role of Medical Litigation: Joint Hearing Before the S. Comm. on the Judiciary and the S. Comm. on Health, Education, Labor, and Pensions*, 108th Cong. 92 (2003) (statement of Lawrence E. Smarr, President, Physician Insurers Ass’n of Am.).

14. See, e.g., Robert Berenson et al., *Issue Brief: Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places*, 68 CTR. FOR STUDYING HEALTH SYSTEM CHANGE 1, 3 (2003) (citing Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 LAW & CONTEMP. PROBS. 57 (1986)).

15. *The Forgotten Third*, *supra* note 11, at 13.

16. See, e.g., Kenneth E. Thorpe, *The Medical Malpractice ‘Crisis’: Recent Trends and The Impact of State Tort Reforms*, 21 HEALTH AFF. WEB EXCLUSIVES W4-20, W4-23-W4-24 (2004), available at <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.20v1/DC1> (reporting that national median malpractice awards have doubled between 1990 and 2001 and that some states report similar increases in frequency).

17. *Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003: Hearing Before H. Comm. on the Judiciary*, 108th Cong. 39 (2003) (statement of Lawrence E. Smarr, President, Physician Insurers Ass’n of America).

future claims associated with these policies. Some insurance companies exited the market as a result of these difficulties, including most notably the St. Paul Insurance Company, whose abrupt departure from the market led to the cancellation of policies for more than 42,000 physicians, 73,000 other health care providers, and 750 hospitals across the country.¹⁸

With managed care plans today exerting considerable control over provider reimbursement rates, physicians are much less able to pass along greater overhead costs to payors than they could in the 1980s. This has led to strong pressure for national reform from health care providers, represented by well-organized groups like the American Medical Association (AMA). AMA representatives have been particularly vocal in arguing that excessive litigation has pushed medical malpractice premiums to unsustainable heights and that providers in many places are being forced out of practice.¹⁹ As of October 2005, the AMA listed twenty states in a full-blown medical liability crisis—compared to twelve in 2002.²⁰ Many other national and state medical organizations have also been active in advocating for national reform.

Physicians have visibly stepped up their lobbying efforts, rallying in front of the U.S. Capitol, marching in state capitols, and conducting behind-the-scenes efforts to influence elected representatives.²¹ They demand a speedy resolution to the crisis, including implementation of a federal cap on non-economic damages. Some states have heeded their call, yet at the national level political gridlock has stalled momentum for the enactment of caps.²² In particular, Republicans generally support a national \$250,000 cap on non-economic damages, but most

18. Robert Bonvino, *Leadership Forum: Why the St. Paul Company's Actions are Important to New York State*, MSSNY WEB, Jan. 2002, http://www.mssny.org/members_only/news/NNY/2002/articles/jan2002articles.htm.

19. See AM. MED. ASS'N, MEDICAL LIABILITY REFORM (2006), <http://www.ama-assn.org/ama/pub/category/7861.html> (reporting that the AMA will “continue to lead an aggressive, multi-year campaign to reduce medical liability premiums”); AM. MED. ASS'N, MEDICAL LIABILITY REFORM – NOW! 4 (2005), available at <http://www.ama-assn.org/go/mlmnow> (reporting current statistics supporting medical liability reform).

20. MEDICAL LIABILITY REFORM – NOW!, *supra* note 19, at 9; Richard G. Roberts, *Understanding the Physician Liability Insurance Crisis*, FAM. PRAC. MGMT., Oct. 2002, available at <http://www.aafp.org/fpm/20021000/47under.html> (citing AM. MED. ASS'N, A NAT'L PERSPECTIVE (2002)).

21. See, e.g., Marguerite Higgins, *Broken System? Doctors Rally for Tort Reform*, WASH. TIMES, April 21, 2005, at C8 (documenting one rally at a U.S. capitol in support of medical malpractice liability reform).

22. See *Congress Renews Debate on Medical Malpractice, AAEM Endorses Bills*, WASH. SENTINEL, Mar. 31, 2005, at 1 (discussing a proposed medical malpractice liability bill to be presented to the House and the Senate); Jan Crawford Greenburg, CHI. TRIB., Sep. 19, 2003, at 2 (documenting political gridlock in the malpractice debate).

Democrats oppose caps in the name of preserving the rights of injured patients to receive fair compensation for their losses.²³

Significantly, almost every sentence in the preceding paragraphs is capable of generating controversy between the impassioned advocates who have fought for or against malpractice reform at the national or state level. Again, some consumer advocates claim that there has been no explosion in claiming severity or frequency, that problems in the market are due to insurance cycles rather than increased claiming, and that the pressure exerted by physicians and insurance companies on political leaders with respect to these issues represents simply an effort to seek an even more favorable legal climate.²⁴ Indeed, the very legitimacy of using the word “crisis” is strongly challenged. At the same time, many physicians and physician advocates strongly argue that malpractice insurance rate increases have little to do with insurance cycles. Perhaps the only point around which there is little dispute is the fact that physicians, especially in high-risk specialties, are paying much more for malpractice insurance coverage today than several years ago.

II. FUNDAMENTAL FAILINGS OF THE CURRENT SYSTEM

And yet, in many ways even this debate misses the larger point. In addition to the substantial and growing burden that malpractice litigation places on health care providers, the current medical malpractice system fails in four other fundamental ways: (1) it compensates few injured patients; (2) it has high administrative costs (which means less money reaches injured patients); (3) it provides little deterrent effect for substandard practices; and (4) it affects the culture of medicine and it hinders quality improvement initiatives by discouraging reporting of information about adverse events in treatment by health care providers.

Few are Compensated

First, a primary goal of the tort system is—as it should be—to compensate adequately and fairly those who have been injured by malpractice. However, research suggests that the system fails to achieve this goal. According to the oft-

23. Compare Jeffrey H. Birnbaum & John F. Harris, *President's Proposed Remedy to Curb Medical Malpractice Lawsuits Stalls*, WASH. POST, April 3, 2005, at A05 (discussing Bush administration proposals to set national non-economic damage caps at \$250,000), with Associated Press, *Bush Pushes for Tort Reform*, CBS News, Jan. 5, 2005, available at <http://www.cbsnews.com/stories/2005/01/05/politics/main664838.shtml> (presenting the opposing view of Sen. Edward Kennedy), and Nancy Pelosi, Address at the Consumer Fed'n of Am. Annual Mtg. (Feb. 27, 2003) (arguing for opposition to “extreme Republican tort reform”).

24. See, e.g., Jenny Anderson, *Study Says Malpractice Payouts Aren't Rising*, N.Y. TIMES, July 7, 2005, at C1 (focusing on Center for Justice and Democracy reports that there has been no explosion in malpractice payouts).

cited 1991 Harvard Medical Practice Study, fewer than 2% of patients injured as the result of provider negligence file a malpractice claim.²⁵ Only about one in fourteen who suffers a serious injury (defined as a disability lasting six months or more) is compensated.²⁶ Considerable additional research has buttressed these findings.²⁷

Inefficiency and Prolonged Proceedings

The second failure is the inefficiency and waste of the current system. As much as fifty-four cents of every dollar paid into the system (including malpractice insurance premiums paid by physicians) pay for attorneys' fees, expert witnesses, and other administrative costs.²⁸ Considerably less than half, therefore, end up in the hands of injured patients. While some of these overhead costs are necessary for the system to operate, much are byproducts of unnecessary and overly complex litigation. In addition, most claims drag on for years through court proceedings before the injured patient receives even one dollar of compensation. Indeed, studies indicate that most malpractice cases take from four to five years to reach a resolution.²⁹

Poor Deterrent Effects

Third, the current medical liability system provides little deterrent effect to physicians, because it does a poor job in distinguishing between care that is and is not negligent. The current legal standard of liability is negligence, but compensation is often awarded to patients regardless of that standard. Research suggests that about 20% of claims are valid; for every one valid claim filed, four are unfounded.³⁰ Although it is true that plaintiffs who have experienced negligent

25. A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence—Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245, 249 (1991).

26. NANCY UDELL & DAVID B. KENDALL, PROGRESSIVE POL'Y INST., HEALTH COURTS: FAIR AND RELIABLE JUSTICE FOR INJURED PATIENTS 1 (2005).

27. See, e.g., David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 MED. CARE 250, 255-56 (2000) (reporting a poor correlation between doctor negligence and the filing of medical malpractice claims); Mark I. Taragin et al., *The Influence of Standard of Care and Severity of Injury on Resolution of Medical Malpractice Claims*, 117 ANN. INTERN. MED. 780, 782 (1992) (suggesting that patients are not compensated adequately and fairly under the current medical malpractice system because the severity of the injury suffered by the plaintiff does not impact the likelihood of payment).

28. See TILLINGHAST-TOWERS PERRIN, *supra* note 1, at 17 (finding that twenty-one cents of every dollar spent on malpractice suits go toward administrative costs, nineteen cents go toward attorneys' fees, and fourteen cents go toward defense costs).

29. Letter from Janet L. Kaminski, Associate Legislative Attorney, to Connecticut General Assembly (Sep. 16, 2004), available at <http://www.cga.ct.gov/2004/rpt/2004-R-0729.htm>.

30. UDELL & KENDALL, *supra* note 26, at 1.

care are relatively more likely to receive compensation, plaintiffs nonetheless receive compensation in about a quarter of the cases where independent experts conclude that no negligence occurred.³¹ Rather than negligence on the doctor's part, a poor outcome is often a key factor in the determination of awards.

Impacts on Culture of Medicine

Finally, medical malpractice litigation has an adverse impact on the culture of medicine (and, as discussed below, on health care quality). In particular, the prevalence of malpractice litigation in the United States has helped to create what some observers have termed a "culture of fear" in medicine that discourages health care providers from disclosing information about mistakes because of fears of litigation and damaging their reputations.³² This serves to limit the flow of information about adverse events in treatment that experts identify as important for reducing errors, improving the quality of care, and saving lives.

In addition, studies indicate that injured patients who have experienced medical injury most want a sincere explanation and apology from their doctors.³³ However, doctors are generally reluctant to admit any failures or disclose information about errors or near-misses when that information could be used against them in court.³⁴ Doctors are also much more likely to practice costly defensive medicine in this context, recommending unnecessary treatment and procedures that either will deter potential litigation or that can be used as evidence in court if they are sued.³⁵

Growing Interest in Alternatives

Just as attention to medical malpractice has increased and then decreased with the crises and subsequent periods of relative stability in the insurance market over

31. *Id.* at 1.

32. See *Reducing the Excessive Burden the Liability System Places on the Health Care Delivery System: Hearing on H.R. 5 Before the Subcomm. On Health of the H. Comm. on Energy and Commerce*, 108th Cong. (2003) (statement of Donald J. Palmisano, President, Am. Med. Ass'n) (discussing the "culture of fear" caused by the litigiousness of American society); COMMON GOOD, FEAR OF LITIGATION STUDY: THE IMPACT ON MEDICINE 8 (2002) (reporting that many physicians administer unnecessary care out of fear of litigation).

33. See, e.g., Jonathon R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447, 1458-59 (2000) (reporting on a medical injury policy utilized in the Lexington, KY, VA hospital that incorporated doctor apology); Daniel Eisenberg, *When Doctors Say, "We're Sorry": Aggrieved Patients Often Just Want an Apology. But Will Admitting a Mistake Increase the Risk of a Lawsuit?*, TIME, Aug. 15, 2005, at 50-51 (reporting on the increased use of apologies in preventing lawsuits).

34. See David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 JAMA 2609 (2005).

35. *Id.* at 2612.

the last thirty years, so too has interest waxed and waned in exploring alternatives to the medical malpractice system. Through the years there have been some bold experiments—for example, the creation in the 1980s of Birth-Related Neurological Injury Compensation programs in Florida and Virginia³⁶—but there has been no fundamental reform at the national level. Although the polarization of interest groups remains strong today, the current pressures for medical malpractice reform are somewhat different than in past crises. In particular, a new factor figures prominently in current reform discussions: patient safety.

Since the beginnings of the current medical malpractice crisis in 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 health care quality and patient safety more than the IOM's 1999 publication of its landmark report, *To Err is Human: Building a Safer Health System*.³⁷ In this report, the IOM revealed that as many as 98,000 people die unnecessarily every year in American hospitals because of medical errors.³⁸ The report concluded that most errors are caused not by individual providers but rather by breakdowns in larger systems of care.³⁹ This report stimulated significant political interest in health care quality, and has led to the development and introduction of numerous legislative initiatives to address these issues.⁴⁰

As interest in patient safety has increased, so too has awareness grown 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 (those errors that do not result in any harm).⁴¹ Only with such data can hospitals and providers analyze the patterns and frequencies of medical error and focus on fixing the system-wide breakdowns that lead to errors. However, fear of litigation in the current system impedes open exchange of information about the epidemiology of errors and near-misses. Significantly, the IOM identified the legal system as a major impediment to improved quality in a 2002 report, entitled *Fostering Rapid Advances in Health Care: Learning from*

36. See MICHAEL H. BROWN, THE ROBERT WOOD JOHNSON FOUNDATION, CAN THE NO-FAULT APPROACH CONTAIN MALPRACTICE INSURANCE COSTS? (Sept. 2002), <http://www.rwjf.org/reports/grr/027070.htm> (reviewing the creation of and the purposes behind Virginia's Birth-Related Injury Compensation Act and Florida's Birth-Related Neurological Injury Compensation Act).

37. COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (Linda T. Kohn et al. eds., 2000) [hereinafter *TO ERR IS HUMAN*].

38. *Id.* at 26.

39. *Id.* at 51.

40. See, e.g., Patient Safety and Quality Improvement Act of 2005, P.L. 109-41, 119 Stat. 424 (codified as amended at 42 U.S.C. 299b-2).

41. COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* 122 (2001).

System Demonstrations.⁴² “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.”⁴³ The report went on to recommend that Congress charter demonstration projects to explore alternatives to the existing approach to resolving medical injury cases.⁴⁴

III. KEY ELEMENTS OF THE HEALTH COURT PROPOSAL

Growing out of the Institute of Medicine’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 author and legal reformer Philip K. Howard, has been the leading national proponent of the health court concept and—with the support of the Robert Wood Johnson Foundation—has been working with a research team from the Harvard School of Public Health to refine the health court proposal and cultivate stakeholder support.⁴⁵

As currently envisioned,⁴⁶ the health court proposal 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 the opportunity to expedite proceedings and get compensation to injured claimants more rapidly.⁴⁷

42. INST. OF MED., *FOSTERING RAPID ADVANCES IN HEALTH CARE: LEARNING FROM SYSTEM DEMONSTRATIONS* 82 (2002).

43. *Id.*

44. *See id.* at 84-85 (asserting that the time is now ripe for implementation of non-judicial approaches in the U.S. to medical injuries).

45. Press Release, Harvard School of Public Health, Harvard School of Public Health and Common Good to Develop New Medical Injury Compensation System (Jan.10, 2005), *available at* <http://www.hsph.harvard.edu/press/releases/press001102005A.html>.

46. For more information about the evolving health court proposal, see COMMON GOOD, AN URGENT CALL FOR SPECIAL HEALTH COURTS (2005), *available at* <http://cgood.org/assets/attachments/130.pdf> (outlining the need for, and goals of, a health court system).

47. *See* Randall R. Bovbjerg et al., *Administrative Performance of “No-Fault” Compensation for Medical Injury*, 60 *LAW & CONTEMP. PROBS.* 71, 90-98 (1997) (comparing results under the traditional tort system and no-fault programs); David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 *JAMA* 217, 219 (2001) (arguing that no-fault systems of compensation respond to patients’ claims “in a manner that is speedy, equitable, affordable and predictable”).

Trained Health Court Judges

The first core element of the health court proposal is that health court judges would 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 continued understanding of the evolving issues in health care.

In today's system, juries are charged with making the decision about whether the physician-defendant met the appropriate standard of care. However, inconsistencies in jury decision-making have helped to create a legal environment in which ambiguous signals are provided to health care providers as to what it will take to avoid litigation. They respond by practicing defensive medicine and remaining silent.

In the health court system, judges with expertise in health care would make decisions about the standard of care. These judges would issue written rulings of these decisions, which would create precedents for future cases and in turn would help to 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 would send clear and consistent signals to health care providers.⁴⁸ By concretely defining and promoting consistent standards, this process also could help to reduce variations in medical practice patterns across populations and geographic areas and improve the standard of care practiced in hospitals both regionally and nationally.

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

Potential for New Liability Standard

The second key element of the health court proposal is that compensation decisions would be based on a standard other than negligence. Health care treatment is considered negligent in today's system if the provider failed to exercise the standard of care that a reasonable person would have exercised in those circumstances. Many experts have identified the negligence standard as contributing to an overemphasis on blaming health care providers for adverse events that have occurred in treatment. This is inappropriate, studies suggest,

48. 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.

because most errors in treatment result not from individual malfeasance but rather from breakdowns in systems of care.⁴⁹

Of particular promise moving forward is the concept of “avoidability,” which is employed in several Scandinavian countries. 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.⁵⁰ 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.⁵¹

Use of the liberalized avoidability standard of recovery would likely help to expand the number of patients who receive compensation. Application of the avoidability standard should also help to separate the medical liability system from emphasis on blaming individual providers. Unlike a negligence event, an avoidable event does not necessarily implicate blame on the provider involved. In Denmark and Sweden, use of the avoidability standard has helped to create a much less combative and litigious environment between physicians and patients, and has helped to provide an incentive for providers to help their patients with the claims process and ensure that they receive appropriate compensation for avoidable injuries.⁵²

Neutral Expertise and Application of Evidence-Based Standards

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; 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,

49. TO ERR IS HUMAN, *supra* note 37, at 28-31.

50. See *Can the United States Afford a “No-Fault” System?*, *supra* note 6, at 3-7 (noting the methods of the Swedish system of no-fault compensation that distinguish between complications that should be reasonably identified and those that are an unavoidable consequence of disease or surgery).

51. See *id.*

52. Martin Erichsen, Head of Dept., Patientforsikringen and Carl Espersson, Legal Advisor, Patient Insurance Ass’n, Presentation at Common Good and Harvard School of Public Health Forum: Administrative Approaches to Compensating for Medical Injuries: National and International Perspectives (Oct. 31, 2005), available at http://cgood.org/assets/attachments/Transcript_-_October_31st_Event.pdf.

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.⁵³

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).⁵⁴ 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 uncontestable 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 the health court.

Scheduled Compensation

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 would 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.

Use of a compensation schedule would help to ensure that more injured patients received compensation, while at the same time lessening the percentage of

53. See AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP’T OF HEALTH & HUMAN SERVS., NAT’L. GUIDELINE CLEARINGHOUSE, www.guideline.gov (last visited Sept. 21, 2006) (providing a “comprehensive database of evidence-based clinical practice guidelines”).

54. See Randall R. Bovbjerg et al., *Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System*, 265 JAMA 2836, 2836, 2841 (1991) (identifying ACEs as “readily identifiable, normally preventable with good care, and nondistorting of medical decision making”); Laurence R. Tancredi & Randall R. Bovbjerg, *Rethinking Responsibility for Patient Injury: Accelerated-Compensation Events, A Malpractice and Quality Reform Ripe for a Test*, 54 LAW & CONTEMP. PROBS. 147, 149 (1991) (explaining ACEs as those events that are predetermined to be avoidable through good care).

total system costs devoted to administrative expenses. 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 United States at a total system cost comparable to that of the existing system.⁵⁵ The research also suggested that such a process could compensate far more patients.⁵⁶ Comparable administrative compensation systems in the United States and overseas devote far less to administrative expenses than the existing tort system.⁵⁷

IV. LEGAL CONSIDERATIONS

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. This rationale is similar to the one marshaled a century ago to support replacing private lawsuits by workers against their employers with a comprehensive scheme of workers compensation laws.⁵⁸

The health court proposal calls for replacing the jury with a judicial decision-maker.⁵⁹ Created as part of a comprehensive regulatory structure intended to benefit both claimants and defendants, however, such a system is consistent with the U.S. Constitution.⁶⁰ Naturally, there are limitations with respect to the federal government ordering the states to take certain policy actions.⁶¹ However, the federal government clearly can provide financial incentives for states to follow federal policies.⁶² Certainly, the federal government has in the past successfully

55. See *Can the United States Afford a "No-Fault" System?*, *supra* note 6, at 31 (concluding that the Utah and Colorado no-fault compensatory models would result in comparable expenditures).

56. See Tancredi & Bovbjerg, *supra* note 54, at 159 (concluding that a no fault compensation plan would cover far more injuries than are brought under the current system).

57. See, e.g., Bovbjerg et al., *supra* note 47, at 93-96 (presenting data on the low administrative costs associated with Florida's Birth-Related Neurological Injury Compensation Association, or NICA); Erichsen, *supra* note 52, at 27 (stating that the administrative costs associated with Denmark's no fault compensation system amount to no more than half of the total health care expenditures of the country).

58. See, e.g., *N.Y. Cent. R.R. Co. v. White*, 243 U.S. 188, 203-08 (1917) (reasoning that a state-created workers' compensation system served to promote the health and safety of employees, and therefore was not unconstitutional).

59. 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.

60. This proposal makes the assumption that Congress has the power to regulate medical malpractice litigation under the Commerce Clause; such an assumption also underlies most other federal malpractice reform proposals.

61. See, e.g., *New York v. United States*, 505 U.S. 144, 188 (1992) (holding that the federal government cannot require states to legislate on the issue of low-level radioactive waste because it would be inconsistent with fundamental principles of federalism).

62. See, e.g., *South Dakota v. Dole*, 483 U.S. 203, 211-12 (1987) (upholding the federal government's conditioning receipt of federal highway funds on the state's adoption of a legal drinking age of 21).

conditioned receipt of federal funds on states' taking certain actions.⁶³ Accordingly, the federal government would be able to provide incentives for states to adopt health courts (as pilot projects, at the very least).

Whether or not a state could assign malpractice claims to an administrative entity without violating Seventh 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.⁶⁴

V. MAKING HEALTH COURTS A REALITY

Health courts have gained substantial support, and a broad bi-partisan coalition has come together to push for the development of pilot projects. Several bills have been introduced in the U.S. Congress to charter pilot projects, and there has been legislative activity at the state level as well.

A number of prominent public health experts and scholars back the concept,⁶⁵ as do numerous 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.⁶⁶ Numerous health care groups have expressed support, including the Joint Commission on Accreditation of Healthcare Organizations, many state and national medical groups, and others.⁶⁷

Some consumer groups support the idea, appreciating the opportunities for increased compensation, expedited legal proceedings, and improved health care quality. For example, representatives from the American Association of Retired

63. See, e.g., *Rust v. Sullivan*, 500 U.S. 173, 198 (1991) (finding that family planning clinics could be restricted from discussing abortion with patients if they accepted federal funding); *Dole*, 483 U.S. at 211-12; *Lawrence County v. Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256, 269-70 (1985) (holding that a state can be compelled to distribute federal funds to local governments); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17-18 (1981) (explaining that Congress must be explicit when conditioning the states' receipt of federal funds).

64. E.g., *Thomas v. Union Carbide Agric. Prods. Co.*, 473 U.S. 568, 593-94 (1985) (upholding Congress' establishment of an administrative process for registering pesticides as part of a comprehensive re-working of federal pesticide law).

65. Among these experts and academics are Margaret O'Kane, President of the National Committee for Quality Assurance; Kenneth Kizer, President and CEO of the National Quality Forum; Helen Darling, President of the National Business Group on Health; Troyen Brennan, President of the Brigham & Women's Hospital Physicians Organization and Professor at the Harvard School of Public Health; and William Brody, President of Johns Hopkins University. COMMON GOOD, *supra* note 46.

66. Who Supports Health Courts?, <http://cgood.org/f-orgendorsements.html> (last visited Sept. 21, 2006).

67. See, e.g., JOINT COMM'N, *supra* note 4, at 31-33; MED. SOC. OF VIRGINIA, 2006 LEGISLATIVE AGENDA, available at <http://www.msv.org/i4a/pages/index.cfm?pageid=6268>.

Persons (AARP) have expressed support for demonstration projects to test the viability of a health court administrative compensation approach to compensating medical adverse events.⁶⁸ Not surprisingly, personal injury lawyers see the proposal as a threat to the status quo. “An unfair and bad idea,” says the current president of the Association of Trial Lawyers of America (ATLA).⁶⁹ Still, the idea of health courts has broad appeal. In a Harris Interactive survey released in 2004, nearly two in three Americans supported the creation of specialized health courts.⁷⁰

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 support. In July 2005, for example, *USA Today* opined that “‘Health courts’ offer cure.”⁷¹ 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.”⁷² *The Economist* has called the health court proposal “a sensible idea” that “ought to make the system less capricious.”⁷³ 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.⁷⁴

Again, several bills have been introduced in Congress to create health court pilot projects. In the House of Representatives, Rep. Mac Thornberry (R-Texas) has introduced legislation to test new model health care tribunals at the state level.⁷⁵ In the Senate, Sen. Max Baucus (D-MT) and Sen. Michael Enzi (R-WY), Chairman of the Senate Committee on Health, Education, Labor, and Pension, 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.⁷⁶ Hearings are expected in 2006. Finally, legislation to create health courts has been introduced in several states,

68. Jackson Williams, Sr. Pol’y Advisor, AARP, Presentation at Common Good and Harvard School of Public Health Forum: Administrative Approaches to Compensating for Medical Injuries: National and International Perspectives (Oct. 31, 2005), available at http://cgood.org/assets/attachments/Transcript_-_October_31st_Event.pdf.

69. Todd A. Smith, Editorial, *Juries Remain Best Medicine*, USA TODAY, July 5, 2005, at 12A.

70. Press Release, Common Good, Harris Interactive Survey Finds that 62 Percent of American Adults Support the Creation of Special Health Courts (June 14, 2004), <http://cgood.org/assets/attachments/74.pdf>.

71. Editorial, *Health Courts Offer Cure*, USA TODAY, July 4, 2005, at 12A.

72. *Id.*

73. *Scapel, Scissors, Lawyer*, ECONOMIST, Dec. 14, 2005, at 30, 32.

74. Editorial, *Malpractice Mythology*, N.Y. TIMES, Jan. 9, 2005, at 12.

75. Medical Liability Procedural Reform Act of 2005, H.R. 1546, 109th Cong. § 2(a) (2005).

76. Fair and Reliable Medical Justice Act, S. 1337, 109th Cong. § 3 (2005).

including New Jersey and Illinois, and additional state legislative activity is expected in the current year.⁷⁷

CONCLUSION

The debate over medical malpractice reform will almost certainly continue to be a very polarized one, with powerful interest groups working hard to prevent meaningful reform in the system. 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 to advance—rather than impede—quality improvement in health care. An administrative health court system represents a very promising approach to compensating injured patients and establishing greater reliability of medical justice. With public support and political leadership, this promising approach to medical justice can become a reality, both through pilot projects and as part of broader system reforms.

77. *E.g.*, A.721, 212th Leg., Reg. Session (N.J. 2006); S.B. 0151, 94th Gen. Assemb., Reg. Session (Ill. 2005).