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# Reform of Medical Liability and Patient Safety: Are Health Courts and Medicare the Keys to Effective Change?

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# REFORM OF MEDICAL LIABILITY AND PATIENT SAFETY: ARE HEALTH COURTS AND MEDICARE THE KEYS TO EFFECTIVE CHANGE?

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It is a truth universally acknowledged that a liability system in possession of too few virtues must be in want of reform.

Or not.

Far from being an easy sell, reform that deals with fundamental problems in the malpractice system has not proven easy to craft, to persuade policy makers to accept, or to implement.[1] An intriguing observation about our Thirty Years War over medical liability reform is how often serious students in the field believe that fundamental reform is appropriate, yet how seldom such reform draws practical attention.[2] Policy makers and casual observers alike are readily distracted from fundamental issues by the dramatic clash of civilizations between medicine and law over malpractice and by the very narrow agendas those professions have been pursuing.[3] Legislative debates since the initial state battles in 1975 have always addressed whether or not to accept caps and other restrictions on tort.[4] Debates

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* Principal Research Associate, The Urban Institute, Washington, D.C.; J.D., Harvard Law School, 1971. This commentary arises out of the author's participation in a joint conference of the University of Maryland School of Law, Center for Dispute Resolution and Law & Health Care Program, on October 28, 2005 [hereinafter C-DRUM 2005], entitled "Beyond the New Medical Malpractice Legislation: New Opportunities, Creative Solutions, and Best Practices for Patient Safety, Tort Reform and Patient Compensation."

1. This paper uses the term "system" as convenient and conventional shorthand, even though the liability system's components were not designed and do not operate in coordinated or systematic fashion.

2. Michelle Mello, a relatively new and most welcome addition to malpractice scholarship, has made this point very effectively. *See, e.g.*, Michelle Mello, Harvard School of Public Health, Address to Alliance for Health Reform Symposium: If Not Caps, What? Ideas for the Next Round of Liability Reform (September 29, 2003) (slides available from the Alliance for Health Reform at http://www.allhealth.org/briefing_detail.asp?bi=25). Work on Medicare-led reform has echoed this observation. *E.g.*, William M. Sage & Eleanor D. Kinney, *Medicare-Led Malpractice Reform*, *in* WILLIAM M. SAGE AND ROGAN KERSH, EDS., MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 318-49 (2006) ("existing reform debate ignores critical failings" at 319).

3. *E.g.*, Randall R. Bovbjerg & Robert A. Berenson, *Surmounting Myths and Mindsets in Medical Malpractice*, URBAN INST. HEALTH POL'Y BRIEF, Oct. 2005, *available at* http://www.urban.org/UploadedPDF/411227_medical_malpractice.pdf [hereinafter *Surmounting Myths*]. The author asks readers' indulgence to invoke the privilege of self-citation, which is needed to cope with extended exposition in limited time and space. Such sources contain voluminous citations to others' work; *Surmounting Myths*, for example, lists a bibliography of relevant references by topic, judgmentally limited to 100 important sources.

4. *Eg.*, Randall R. Bovbjerg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card*, 22 U.C. DAVIS L. REV. 499, 538-43, 543 tbl.3 (1989) [hereinafter *Preliminary Report Card*].

have almost never considered better ways to improve medical care and safety. Caps are of course vehemently promoted by medical interest groups and their allies from insurance and business, with some success during periods of liability insurance crisis,[5] and just as vehemently resisted by trial lawyers and their allies.[6]

Policy makers can now see that the latest malpractice crisis is ebbing, as insurers return to the market and practitioners can readily find coverage. The crisis of the early 2000s was the third to be declared since 1975 and resulted in a number of new state enactments[7] and much federal legislative activity, although no major new statutes.[8] Opponents of liability reform somewhat glibly suggest that all the crises have been the same and that all have disappeared on their own,[9] but in fact each has left in its wake higher insurance prices and lower risk-spreading for medical providers.[10] Another difference in the current era is that there is now a philosophical and practical alternative to relying solely on legal remedies to deal with erring medical providers—the quality-improvement and patient-safety movements that have been gathering strength since the early to mid-1990s.[11] It is

5. As for "malpractice system," readers are spared the quotation marks that should be on "malpractice crisis" each time the term is used. Liability insurance problems are routinely conflated with underlying malpractice or tort problems, and "crisis" is not an objective term but rather a political label attached for political ends in debates about malpractice policy. *See* Randall R. Bovbjerg, *Malpractice Crisis and Reform*, 32 CLINICS PERINATOLOGY 203, 205-06 (2005) [hereinafter *Malpractice Crisis and Reform*] (considering competing claims about the extent, causes and effects of the "crisis"). Political declarations of crisis are common in many other policy arenas as well, including social security. *E.g.*, Richard Morin & Dale Russakoff, *Social Security Problems Not a Crisis, Most Say*, WASH. POST, Feb. 10, 2005, at A1.

6. This vehemence, if not venomousness, of the contending parties and the tens of millions of dollars they spend on lobbying and propaganda are reasons to seek a different metaphor from Sage-Kinney's observation that "malpractice policy has been in suspended animation for decades." Sage & Kinney, *supra* note 2, at 1. Rather, the policy debate seems more like trench warfare—an endless war fought over the same terrain, with alternating periods of pitched battle and uneasy truce.

7. *See generally, eg.*, AM. TORT REFORM ASS'N, TORT REFORM RECORD: DECEMBER 2005 2-3 (2005), http://www.atra.org/files.cgi/7990_Record_12-31-05.pdf (providing a state-by-state summary of ATRA-supported reforms).

8. The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2005, H.R. 5, passed the House in July 2005 but has not moved out of committee in the Senate. H.R. 5, 109th Cong. (2005). However, the Class-Action Fairness Act of 2005 was successfully enacted. H.R. 516, 109th Cong. (2000); Press Release, President George W. Bush, President Signs Class-Action Fairness Act of 2005 (Feb. 18, 2005), *available at* http://www.whitehouse.gov/news/releases/2005/02/print/20050218-11.html.

9. *E.g.*, Ctr. for Justice & Democracy, Mythbuster: the Liability Insurance Crisis-Déjà Vu All over Again, http://www.centerjd.org/free/mythbusters-free/MB_Dejavu.doc.pdf (last visited Sept. 21, 2006).

10. *Malpractice Crisis and Reform*, *supra* note 5, at 206-08.

11. The two Institute of Medicine (IOM) books cited by Sage and Kinney respond to and exemplify this changing climate. INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001) [hereinafter CROSSING THE QUALITY CHASM]; INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (L.T. Kohn et al. eds., 2000) [hereinafter TO ERR IS HUMAN].

these movements into which advanced liability reforms like those considered here seek to tap.

## I. PATIENT SAFETY, INJURY REMEDIATION, AND TWO PROPOSALS

Initiatives in quality improvement and in patient safety offer new ways to actively promote better and safer care.[12] These approaches hold promise of a more productive approach than liability, which simply waits for injuries to occur, for some patients to perceive fault and bring lawsuits, then years after the fact punishes a fraction of sued caregivers if their behavior can be proved through tort process negligently to have caused injury.[13] However, early safety theory gave preeminent importance to developing systems to prevent errors from occurring or reaching future patients. The approach was wholly divorced from helping patients who have been injured by practitioner or systems errors in the here and now.

Safety theorists extolled the virtues of a "blame free" culture within medical institutions in order to foster internal learning about mistakes and injuries, unfettered by practitioner fear of liability or regulatory sanction.[14] Indeed, the central legislative thrust of safety advocates was to keep their information on mishaps hidden from liability.[15] Resisting patient recourse through liability while offering nothing in its place was transparently unfair to injured people and politically harmful in appearing to dodge external accountability for injury.[16]

More advanced safety theory is at least beginning to address the plight of injured patients. This shift is visible in the "say you're sorry" approach to resolving injuries, which seeks immediate disclosure and remediation for injured

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12. *Id.*

13. One highly publicized recent patient safety initiative led by the Institute for Healthcare Improvement (IHI) set a goal of avoiding 100,000 in-hospital deaths by adopting proven preventive measures. IHI has reported that as of June 14, 2006, an estimated 122,300 lives had been saved. See the campaign webpage at http://www.ihi.org/IHI/Programs/Campaign/ (last visited Sept. 21, 2006).

14. Randall R. Bovbjerg, Robert H. Miller, and David W. Shapiro, *Paths to Reducing Medical Injury: Professional Liability and Discipline vs. Patient Safety-and the Need for a Third Way*, 29 J.L. MED. & ETHICS 369, 370 (2001); *see also* TO ERR IS HUMAN, *supra* note 11, at 49-68.

15. *Patient Safety: Instilling Hospitals with a Culture of Continuous Improvement: Hearing Before the Comm. on Governmental Affairs*, 108th Cong. 6 (June 11, 2003) (statement of Dennis O'Leary, President, Joint Comm. on Accreditation of Healthcare Org.), http://www.jointcommission.org/NewsRoom/OnCapitolHill/testimony_061104.htm. The Patient Safety and Quality Improvement Act of 2005 passed soon after the Senate Committee meeting, and was later signed into law by President Bush. Patient Safety and Quality Improvements Act of 2005, Pub. L. No. 109-41, 119 Stat. 424 (to be codified at 42 U.S.C. § 299b); Press Release, President George W. Bush, President Signs Patient Safety and Quality Improvement Act of 2005 (July 29, 2005), *available at* http://www.whitehouse.gov/news/releases/2005/07/20050729.html.

16. Randall R. Bovbjerg & Laurence R. Tancredi, *Liability Reform Should Make Patients Safer: "Avoidable Classes of Events" are a Key Improvement*, 33 J. L. MED. & ETHICS 478, 479 (2005).

patients, sometimes with offers of measured compensation.[17] Another indicator is the emergence of a "just culture" philosophy of "fair" accountability for avoidable problems, including disregard for established safety protocols in place of a blame-free culture.[18]

The perspective of this commentary is that proposed reforms of malpractice should be judged on how well they can combine the two currently separate social mechanisms—the tort adjudicatory system that now compensates some injured patients and the emerging systems that seek to improve medical care and safety for all patients. This viewpoint is applied to two emerging reform proposals, for "health courts" and for "Medicare-led reform."[19] The health courts proposal comes from Common Good, an advocacy group founded by Philip K. Howard, for which the byword is "restoring common sense to American law."[20] Its advocate in

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17. *E.g.*, Doug Wojcieszak, *When Doctors Say They're Sorry,* BOSTON GLOBE, Aug. 25, 2005, at A1 (discussing hospitals around the country that are instituting policies of apologizing for medical errors); *see* Sorry Works! Coalition webpage, http://www.sorryworks.net (last visited Sept. 4, 2006).

18. The leading theorist appears to be David Marx. *See* DAVID MARX, PATIENT SAFETY AND THE "JUST CULTURE": A PRIMER FOR HEALTH CARE EXECUTIVES 3-4, 17-18 (2001), *available at* http://www.usuhs.mil/cerps/documents/ps_justculture.pdf; The Just Culture Community, http://www.justculture.org/ (last visited Sept. 21, 2006) (questioning the efficacy of the American system of blame and punishment in preventing future medical injuries); *see also* Jim Conway, Address to the Patient Safety Workshop, Health Systems Planning, Oregon Department of Human Services: Accountability: An Organizational and Environmental Perspective (Feb. 4, 2004), http://www.oregon.gov/DHS/ph/hsp/patientsafety/docs/jim-conway-at-meetingl.ppt (describing a similar philosophy by the Dana-Farber Cancer Institute, a leading Boston institution).

19. The current article comments upon the overall scholarship underlying health courts and Medicare-led reform, as it had to be written at the same time as the Sage and Barringer contributions in this issue, William M. Sage, *The Role of Medicare in Medical Malpractice Reform*, 9 J. HEALTH CARE L. & POL'Y 217 (2006) [hereinafter *Medicare Malpractice Reform*] and Paul J. Barringer, III, *A New Prescription for America's Medical Liability System*, 9 J. HEALTH CARE L. & POL'Y 235 (2006) [hereinafter *New Prescription*]. Accordingly, this commentary largely relies upon the prior record, including the Sage and Barringer presentations at the C-DRUM 2005, *supra* note *). The following articles reflect much of the intellectual development over time. On health courts (often called "medical courts"), see Common Good, "An Urgent Call for a Reliable System of Medical Justice" (petition), advertised in The New York Times, Mar. 2, 2003, http://cgood.org/healthcare-52.html; Nancy Udell & David B. Kendall, *Health Courts: Fair and Reliable Justice for Injured Patients*, PROGR. POLICY INST. POLICY REPORT, Feb. 17, 2005, *available at* http://www.ppionline.org/documents/healthcourts_0217.pdf; and Paul Barringer, *Health Courts: A Better Approach to Malpractice Reform*, 14 BNA HEALTH LAW REP. 877 (2005). On Medicare-led reform, see William M. Sage, *The Forgotten Third: Liability Insurance And The Medical Malpractice Crisis*, 24 HEALTH AFFAIRS 10 (no. 4, July/August 2004) (paragraph on Medicare-and-Medicaid-led reform at 20); Sage & Kinney, *supra* note 2, of which the draft of August 2005 was available for this commentary, as well as an issue brief of the same name from January 2005 done for an AcademyHealth conference, http://www.academyhealth.org/nhpc/2005/sagekinney.pdf (last visited Sept. 21, 2006); and Eleanor D. Kinney and William M. Sage, *Resolving Medical Malpractice Claims in the Medicare Program: Can It Be Done?*, 12 CONN. INSUR. LAW J. 77 (2005). Law review editors have added some citations to *Medicare Malpractice Reform* and *New Prescription, supra.*

20. This vision cum motto heads Common Good's webpage, http://cgood.org (last visited Sept. 21, 2006).

this issue is Paul Barringer, who also presented at the 2005 conference.[21] Medicare-led reform is championed here by Professor William Sage, drawing upon his work with Professor Eleanor D. Kinney.[22] This commentary ends with proposals of its own.

The University of Maryland conference "Beyond the New Medical Legislation: New Opportunities, Creative Solutions, and Best Practices for Patient Safety, Tort Reform and Patient Compensation"[23] and these resulting articles are timely. The aftermath of an insurance crisis is potentially a good time to advance development and demonstrations of tort reforms that go beyond caps on awards and other conventional limitations.[24] Policy makers should now be less preoccupied with fighting the tort reform battle of the moment, and there may well be less political pressure from medical interests to consider only caps as a "solution." Certainly, further development of reforms and demonstration of their feasibility and efficacy needs to start now if better reform alternatives are to be available as policy options before the next malpractice crisis arrives. Despite the conceptual appeal of alternative reforms, much more work is needed to make them a reality.

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21. Mr. Barringer is Common Good's general counsel and heads its health court initiative. Common Good, Senior Staff, http://cgood.org/learn-people-staff.html (last visited Sept. 4, 2006).

22. Sage and Kinney received a Commonwealth Fund grant to develop their proposal in summer 2004; see also the sources cited at note 19. Full disclosure: This commentator is no stranger to any of these actors. Eleanor Kinney engaged me as a consultant on her first malpractice project, in the late 1980s. *See* William P. Gronfein & Eleanor DeArman Kinney, *Controlling Large Medical Malpractice Claims: The Unexpected Impact of Damage Caps*, 16 J. HEALTH POL. POL'Y & L. 441, 441 (1991), published with commentary by Randall R. Bovbjerg, *Lessons for Tort Reform from Indiana*, 16 J. HEALTH POL. POL'Y & L. 465 (1991) [hereinafter *Lessons for Tort Reform from Indiana*]. Nancy Udell, Mr. Barringer's predecessor at Common Good, and I were keynote presenters at a conference on *Non-Adversarial Ways to Enhance Patient Safety & Provide Compensation for Maloccurrences*, (Luzerne County Medical Society Conference, April 9, 2003); proceedings were privately published, reported in Jane-Ellen Robinet, *Task Force Fails to Avert Protest*, PHYSICIAN'S NEWS DIGEST, May 2003, http://www.physiciansnews.com/cover/503.html. Professor Sage, Mr. Howard, and I all served on the 2004-2005 Tort Resolution and Injury Prevention Roundtable of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which produced a white paper available from http://www.jointcommission.org/PublicPolicy/tort.htm (last visited Sept. 21, 2006). Professor Sage and I also participated in 2005 conference calls with the Centers for Medicare & Medicaid Services (CMS) to discuss Medicare-led reform. Finally, Professor Sage, in his capacity as the director of the Pennsylvania Medical Liability Project, twice commissioned papers from me. RANDALL R. BOVBJERG & ANNA BARTOW, PROJECT ON MED. LIAB. IN PENN., UNDERSTANDING PENNSYLVANIA'S MEDICAL MALPRACTICE CRISIS: FACTS ABOUT LIABILITY INSURANCE, THE LEGAL SYSTEM, AND HEALTH CARE IN PENNSYLVANIA, *available at* http://www.pewtrusts.org/pdf/vf_medical_malpractice_0603.pdf (last visited Sept. 21, 2006); Randall R. Bovbjerg & Robert A. Berenson, *Enterprise Liability in the 21st Century*, *in* MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 219-244 (William M. Sage & Rogan Kersh eds., 2006).

23. C-DRUM 2005, *supra* note *.

24. *See generally* Randall R. Bovbjerg, Principal Researcher, Urban Inst., Remarks at Joint Commission on Accreditation of Healthcare Organizations Press Conference (Feb. 10, 2005), *available at* http://www.jointcommission.org/NewsRoom/PressKits/TortReform/transcript.htm.

## II. THE SYSTEMS PROBLEMS

Why should there be fundamental reform? Because there are fundamental shortcomings in all three systems relevant to malpractice policy—medicine, law, and insurance.[25] (Many of the following points appear in the Barringer and Sage articles in this issue.)

First and foremost is the *medical system*; promoting good medical care is the preeminent public interest. American medical services are often very good. Their efficacy is shown by better health outcomes and longevity among people with good, insured access to care, as compared to uninsured Americans.[26] Nonetheless, performance could be much better, both for medical quality (routinely taking appropriate steps to reduce risks from illness and accident) and for patient safety (avoiding introduction of preventable new risk from medical action or inaction). Too many patients get too much care, too little care, or the wrong care; and too many patients are injured by their medical care. Two recent Institute of Medicine books have made these points with considerable eloquence and substantial documentation.[27]

Second, the tort law system would be well worth its direct cost of approximately 1.5% of medical spending[28] if it actually achieved the benefits of compensation for injured patients, deterrence of substandard care, and provision of justice that tort jurisprudence and opponents of tort reform claim that system guarantees.[29] But it does not.[30] Compensation falls short because a low percentage of injured patients sue and fewer still collect, payouts are slow and somewhat erratic, and overhead costs are very high. Deterrence is the main rationale for tort, yet there is very little evidence that it makes medicine safer.[31] Tort law and

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25. Randall R. Bovbjerg, *Medical Malpractice: Problems & Reforms—A Policy-Maker's Guide to Issues and Information* (URBAN INST.-INTERGOVMENTAL HEALTH POL'Y PROJ. ed., 1995) (on file with author) [hereinafter *Problems & Reforms*].

26. *See* Jack Hadley, *Sicker and Poorer: The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income*, 60 MED. CARE RES. & REV. 3S, 65S (2003) (providing a review of the research showing that uninsured Americans have a significantly higher risk of death than the privately insured).

27. CROSSING THE QUALITY CHASM, *supra* note 11; TO ERR IS HUMAN, *supra* note 11.

28. *See* Cong. Budget Office, Limiting Tort Liability for Malpractice, Issue Summary, Jan. 8, 2004, at 1, *available at* http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf.

29. Randall R. Bovbjerg, *Medical Malpractice on Trial: Quality of Care Is the Important Standard*, 49 LAW & CONTEMP. PROBS. 321, 321-22 (1986).

30. Randall R. Bovbjerg, Letter to the Editor, *Better Medical-Injury Systems*, 23 HEALTH AFF. 277, 277 (2004).

31. Randall R. Bovbjerg & Laurence R. Tancredi, *Liability Reform Should Make Patients Safer: "Avoidable Classes of Events" are a Key Improvement*, 33 J. L. MED. & ETHICS 478, 479 (2005); Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1595-1623 (2002); *see* Randall R. Bovbjerg & Frank A. Sloan, *No Fault for Medical Injury: Theory and Evidence*, 67 U. CIN. L. REV. 53, 81 (1998) (mixed evidence suggests that tort incentives may improve road safety, but not medical safety). The most

process do better in resolving individual disputes than physicians appreciate or than Barringer and Sage acknowledge,[32] but any injury prevention is piecemeal rather than systematic and effective. In sum, as recently noted, "standards of fault and causality are vague and inconsistent, experts routinely disagree, results are unpredictable, and high rates of preventable error and injury persist."[33] Whatever level of deterrence liability may be achieved must be set against its counterproductive effects. Legal fears also cause some over-deterrence in the form of defensive medicine, deprive quality reformers of information about problems by making practitioners reluctant to disclose or discuss mistakes or injuries lest they face lawsuits, and erode the therapeutic value of physician-patient trust.[34]

Tort process offers individual justice in the form of procedural fairness for litigants—that is, giving them full opportunity to hire lawyers and expert witnesses of their choice as well as wide procedural latitude to make their case. But system justice is quite weak. Most injured patients never enter the legal system, justice for those who do litigate is delayed by very slow dispute resolution, and fairness is ill-served by somewhat haphazard results, given the inability of tort law's case-by-case approach to achieve either horizontal or vertical equity across cases[35]—a point also emphasized by Barringer and Common Good. Some litigants are satisfied,[36]

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elaborate, and ultimately unsuccessful, attempt to demonstrate deterrence in medical care came in a thorough study of New York hospital experience summarized in PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 124-34 (1993) and discussed in Mello & Brennan, *supra*.

32. Evidence and discussion about case resolution is contained in, e.g., Mark I. Taragin et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims,* 117 ANNALS INTERNAL MED. 780-84 (1992); TOM BAKER, THE MEDICAL MALPRACTICE MYTH 1-19 (2005); NEIL VIDMAR, MEDICAL MALPRACTICE AND THE AMERICAN JURY (1995).

33. Bovbjerg & Tancredi, *supra* note 16, at 479. TO ERR IS HUMAN, *supra* note 11, summarizes studies showing a substantial level of preventable injury (at 215-53); two leading studies are Troyen A. Brennan et al., *Incidence and Types of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I,* 324 N. ENGL. J. MED. 370, 371 (1991) and Eric J. Thomas et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado,* 38 MED. CARE 261 (2000).

34. Counterproductive defensiveness surely exists to some extent; and, although its negative fiscal and other impacts are almost impossible to quantify, they seem just as well documented as the positive effects of legal deterrence, some of which probably also occur. *See generally, e.g.*, Randall R. Bovbjerg et al., *Defensive Medicine and Tort Reform: New Evidence in an Old Bottle,* 21 J. HEALTH POL. POL'Y & L. 267, 267-88 (1996) (reviewing the research on defensive medicine). On issues of trust, see Robert A. Berenson, *Malpractice Makes Perfect,* NEW REPUBLIC, Oct. 10, 2005.

35. Bovbjerg & Tancredi, *supra* note 16, at 479; Randall R. Bovbjerg & Brian Raymond, Patient Safety, *Just Compensation and Medical Liability Reform* 1, 7-11, 17, KAISER PERMANENTE INST. FOR HEALTH POL'Y REP. (Jan. 2003), *available at* http://www.kpihp.org//publications/docs/patient_safety.pdf (last visited Sept. 21, 2006); *accord* David M. Studdert et al., *Medical Malpractice,* 350 N. ENGL. J. MED. 283, 285-86 (2004) (mismatch of tort claims and results to true negligence).

36. FRANK A. SLOAN ET AL., SUING FOR MEDICAL MALPRACTICE (1993) (summarizing at page 9 that malpractice claimants "appear to be satisfied with the process even when they do not receive compensation").

but others are very critical of the process.[37] These deep-seated, severe, and ongoing problems for tort law as applied to medicine are much stronger policy grounds for reform than are periodic and impermanent liability insurance crises.

Third, the funding mechanism of liability insurance has proved able to survive repeated shocks. However, its assumption of fiscal responsibility for harm undercuts whatever useful deterrence might come from the imposition of tort damages, because by definition insurance pools those losses across insureds[38] and thereafter fails to ameliorate this inherent shortcoming by using experience rating to set physicians' premiums.[39] Moreover, the unpredictability of legal results makes it difficult to price coverage accurately. This uncertainty, together with a high average payout size and the "long tail" of time before payout, makes malpractice coverage even more susceptible to wide swings in price and availability (the crises) than is the general property-casualty insurance industry of which malpractice coverage is a part.[40]

## III. PROBLEMS FOR REFORM

Why is there no fundamental reform? After all, the arguments presented above—and the case for at least experimenting with more fundamental change—have been accumulating since before the first national malpractice crisis. Many points began to be developed in the very first systematic examination of the malpractice "system" and other early writing.[41] Why has there been so little interest in reforms with promise to better serve the public interest?

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37. R. GIBSON & J.P. SINGH, WALL OF SILENCE: THE UNTOLD STORY OF THE MEDICAL MISTAKES THAT KILL AND INJURE MILLIONS OF AMERICANS 213 (2003) (quoting complaints of anonymous patient family members); *accord* Stephen D. Sugarman, *A Century of Change in Personal Injury Law*, 88 CAL. L. REV. 2403, 2429-30 (2000) (questioning extent to which tort claimants receive satisfying sense of justice).

38. *See* PROSSER & KEETON ON THE LAW OF TORTS 584-96 (W. Page Keeton ed., 5th ed., 1984). This is a general concern, not limited to medical liability.

39. *See* Richard S. L. Roddis & Richard E. Stewart, *The Insurance of Medical Losses*, 1975 DUKE L.J. 1281, 1302 (1976) (noting the little use of experience-based rating for malpractice, unlikecasualty coverage); Frank A. Sloan, *Experience Rating: Does it Make Sense for Medical Malpractice Insurance?*, 80 AM. ECON. REV. 128, 129, 132 (1990) (analyzing merits of experience rating for physician coverage); William M. Sage, *The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis*, 23 HEALTH AFF. 10 (2004) (asserting that "experience rating at the individual physician level is too imprecise to be effective").

40. Bovbjerg, *Malpractice Crisis and Reform*, *supra* note 5, at 209; *see* TOM BAKER, THE MEDICAL MALPRACTICE MYTH 54 (2005).

41. The initial landmark study of the unsystematic liability system was performed by the U.S. Department of Health, Education and Welfare (DHEW) in 1973. Report of the Secretary's Commission on Medical Malpractice (Washington, DC: DHEW, pub. no. (OS) 73-88m Jan. 16) and DHEW 1973. Appendix, Report of the Secretary's Commission on Medical Malpractice (Washington, DC: DHEW, pub. no. (OS) 73-89, Jan. 16) (containing numerous studies). For historical perspective, *see generally* Randall R. Bovbjerg, *Medical Malpractice: Research and Reform*, 79 VA. L. REV. 2155 (1993) (reviewing Weiler et al., supra note 31); Clark C. Havighurst & Laurence R. Tancredi, *Medical*

The Sage analysis begins by suggesting that the key problem is that "medical malpractice policy has never [been] integrated with overall health policy."[42] This is an appealing formulation for the arguments developed by Sage and Kinney, as it implies easy sailing for their integrative approach of using Medicare to lead reform. However, problems run deeper than this. It is certainly unfortunate that third party payers have never engaged in malpractice debates. They are the ones, after all, that pay the most for medical injuries, just as for other injuries.[43] The liability system pays only for the small share who litigate and win and often not enough for full coverage of very severe cases.[44] Conventional "collateral source offset" tort reform shifts even more costs to health insurance from liability insurance.[45] Large health plans, including Medicare, appear to have ceded the malpractice debate to medical interests because they do not want to alienate the service providers needed to serve health plan enrollees.

Whether for this or other reasons, interest group politics predominate, and medical and legal interest groups have always "owned" the malpractice issue. The opposing armies in policy battles are led by doctors and plaintiffs lawyers, who not only have opposing economic interests but also a broader conflict over which profession should be in charge of defining socially legitimate ways to decide upon the appropriateness and safety of medical care. Over thirty years, their opposing contentions have become quite routinized, although frequently repolished with new factoids, often from non-peer-reviewed "studies."[46] Ironically, a dirty little secret about their debates is that neither set of advocates is entirely unhappy with the under-performing liability system itself—although physicians want it to cost a little less while attorneys want to expand its scope.

This bitter but narrow debate is disheartening on two main grounds. First, its sheer volume tends to drown out discussion of the more serious problems of patient safety. Second, medical interest groups have cast policy-making as a zero sum game by promoting what have been called *takeaway tort reforms*—every dollar that caps and similar cutbacks save for doctors (through their insurers)

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*Adversity Insurance—A No-Fault Approach to Medical Malpractice and Quality Assurance*, 51 MILBANK MEMORIAL FUND Q. 125 (1974) (proposing medical adversity insurance and other early reform alternatives). *See generally* Bovbjerg & Berenson, *supra* note 3 (providing a current perspective after thirty years of medical malpractice debate and advocating alternative reforms for the future); Michelle. M. Mello, *Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms*, ROBERT WOOD JOHNSON FOUND. RES. SYNTHESIS REP. no. 10 (May 2006), http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no10_researchreport.pdf (literature review on tort reform) (last visited Sept. 21, 2006).

42. Sage & Kinney, *supra* note 2, at 318.

43. *Lessons for Tort Reform from Indiana*, *supra* note 22, at 474.

44. *See* SLOAN ET AL., *supra* note 36, at 220 (discussing malpractice under-compensation by of injured patients in Florida study).

45. *See infra* p. 263 (discussing conventional reforms).

46. Bovbjerg & Berenson, *supra* note 3, at 1.

comes directly out of the pockets of claimants (and proportionately from their contingent-fee attorneys).[47] Sadly, with a brief exception in the late 1980s,[48] neither side has proposed a potentially win-win reform that might save money or provide better value for patients, payers, and practitioners by reducing injuries, regularizing compensation, and slashing disputation's very high costs in time and dollars.

Finally, legal interests have done a good job promoting the liability system. They have a simple and appealing story to tell: make negligent tortfeasors responsible for full tort damages and they will commit less negligence. And they tell it well, if with rather more emotion than evidence in the case of medicine. Medical interests, in sharp contrast, have failed to convince the public that the current liability system does not work. This should not be surprising, for they have set as their task promoting a slimmed-down version of the same system. They did not help their case for legal reform when they made common cause with trial attorneys in supporting "patient protection" reform to prevent managed-care incursions into their professional autonomy by promoting litigation with detailed courtroom review of medical decision-making.[49] Nor has patient safety sold itself as an alternative to tort, preferring to distance itself from legal entanglements.[50] Tellingly, opinion surveys find that the public has assimilated one lesson of patient safety research, that too many people are injured in the course of medical care. But the citizenry at large believe that the appropriate safety fix is more lawsuits and more state discipline of physicians[51]—approaches that the medical professionals dislike and that patient safety advocates believe counterproductive[52]—not new and more effective approaches to safety.

To be successful, better reform needs to appeal to physicians, of course, because they are central to production of medical care and to safety improvements, but it must also appeal to patients.[53] Reforms should help the vast majority of

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47. Bovbjerg, *Lessons for Tort Reform from Indiana*, *supra* note 22, at 467 (zero-sum nature of caps).

48. *See infra* p. 264 (discussing late 1980s AMA and specialty societies' proposal for an administrative compensation system).

49. *See generally* Mark A. Peterson, ed., *The Managed Care Backlash*, 24 J. HEALTH POL. POL'Y & L. 876, 876-1032 (1999).

50. The Institute of Medicine, for example, called for a non-adversarial, blame-free approach to safety, but explicitly side-stepped calling for legal reform. TO ERR IS HUMAN, *supra* note 11, at 5-15. For a detailed argument about this aspect of patient safety ideology, see Bovbjerg & Tancredi, *supra* note 16, at 478-81.

51. Robert J. Blendon et al., *View of Practicing Physicians and the Public on Medical Errors*, 347 N. ENG. J. MED. 1933, 1936-37 (2002).

52. Randall R. Bovbjerg et al., *supra* note 14 (describing and discussing the conflict between these worldviews).

53. *See* Stephen C. Schoenbaum & Randall R. Bovbjerg, *Medical Malpractice Reform Must Include Steps to Prevent Medical Injury*, 140 ANNALS INTERNAL MED. 51, 51 (2004) (arguing that the current system poorly serves physicians and patients alike).

patients, the uninjured ones, by promoting improvements in care across the board and also reducing injury risks. By definition, patients whose care improves under reform will not recognize that they might otherwise have been injured, but it is important to document improvements on a population basis (Medicare-led reform has great promise for doing this). Another aspect of appealing to patients is demonstrably better treatment for the small share of patients who are injured. The traditional silent treatment of hunkering down, circling the wagons, stonewalling—choose your metaphor—is infuriating for injured people and their families and alienates many natural allies who want better medicine.[54] Happily, there is growing acceptance that disclosure is not only ethically appropriate but also, done right, good liability damage control. It is much better to tell injured people promptly about the problem (which may sometimes be difficult to diagnose) and about the plan for amelioration—including reasonable payment. Legal fears as well as professional reticence, hardly unique to medical practitioners, still inhibit such disclosure. Again, any provider-led reform, possibly including Medicare-led reform, has a head start on changing provider behavior.

Not every injured patient can be made better off, as today a few win huge verdicts under the traditional liability system—but most can be helped by faster, more certain, and less adversarial handling of their problems. To be successful, reform also needs to address a key emotional-philosophical support for traditional courtroom-based fault-finding, that is, punishing egregious misbehavior (e.g., the drunken surgeon) and the truly incompetent (e.g., the badly out-of-date practitioner). Such practitioners account for a small minority of injuries[55] but loom large in the popular imagination and make great theatre in the legislative hearing room and fine test cases for judicial review of reform legislation.[56]

Enter health courts and Medicare-led reform.

## IV. HEALTH COURTS AND MEDICARE-LED REFORM PROPOSALS IN POLICY CONTEXT

These reforms both, to different degrees, attempt to bring legal reform into the patient safety era, in common with all reforms of what Professor Kinney has called the third generation of malpractice reform.[57] Existing reforms and reform proposals display three levels of thoroughness of reform . . . and ease of implementation.

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54. *See generally* GIBSON & SINGH, *supra* note 37.

55. This observation first came to me from Professor Jeffrey O'Connell, a long-time tort reformer. *See* Bovbjerg & Tancredi, *supra* note 16, at 492.

56. As has recently been said in another context, "Lawyers don't take kindly to being told that their skills aren't needed." Corine Hegland, *Guantanamo's Grip*, NAT'L J., Feb. 3, 2006.

57. Eleanor D. Kinney, *Learning from Experience: Malpractice Reforms in the 1990s: Past Disappointments, Future Success*, 20 J. HEALTH POL. POL'Y & L. 99, 117-18 (1995).

Liability reforms differ in the extent to which they change the traditional legal system. Conventional tort reforms were the first generation of reform.[58] They are state-legislated, pro-defendant changes to the states' rules of tort law, without modifying its basic structure, processes, or financing.[59] Such reforms mean to reassure liability insurers by rolling back or halting the trend in favor of plaintiffs in judicially developed tort law,[60] but not to abandon the fault regime or judicial dispute resolution. These reforms leave the same basic legal system in place, but make it harder to sue (e.g., reduced statute of limitations, limits on legal fees), harder for plaintiffs to win (e.g., rules on expert witnesses), or harder to collect large amounts of damages (e.g., caps on awards, collateral source offset).[61] First generation, conventional reforms—particularly caps, collateral source offsets, and shorter statutes of limitation—are known to "work" in the way they were intended to. That is, they reduce claims and payouts, and ultimately premiums by up to 30% over time.[62] They are not known, however, to make medical services safer or very much more available.[63]

Second-generation reforms would make greater changes in liability rules while still retaining the fault basis of responsibility and provider-based financing. Such reform proposals include various forms of alternative dispute resolution (ADR),[64] more thoroughgoing "scheduling" of damages especially for non-

58. *Id.*; *Problems & Reforms*, *supra* note 25.

59. Parallel federal reform has been actively sought but not yet enacted. Congressional Republicans' Contract with America in the mid-1990s and the Bush Administration in the 2000s have sought federal legislation to impose national reform at least equivalent to California's state reforms of 1975. Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2005, H.R. 5, 109th Cong. (2005). The administration's case for the bill appears in the Office of the Assistant Sec'y for Planning & Evaluation, *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System,* U.S. DEP'T OF HEALTH & HUMAN SERVS. REP., July 24, 2002, *available at* http://aspe.hhs.gov/daltcp/reports/litrefm.pdf.

60. PATRICIA M. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY 58-65 (1985) documents how pre-reform changes in tort law contributed to higher claims rates and payouts—which first-generation reforms aim to reverse.

61. *Preliminary Report Card*, *supra* note 4.

62. Savings of 25-30% is the estimate that the nonpartisan Congressional Budget Office made in assessing the combined impact of the tort reforms in H.R. 5. *See* Cong. Budget Office, *supra* note 28, based on its review of research, later published at http://www.cbo.gov/ftpdocs/55x (last visited Sept. 21, 2006). A different literature review does not estimate combined savings but suggests lower savings from individual reforms. Mello, *supra* note 41.

63. Studies have had mixed findings on whether a state's caps or other tort reforms increase its supply of physicians. *Compare* Daniel P. Kessler et al., *Impact of Malpractice Reforms on the Supply of Physician Services*, 293 JAMA 2618, 2618–25 (2005) (small effect), *with* K. Baicker & A. Chandra, *The Effect of Malpractice Liability on the Delivery of Health Care*, *in* FRONTIERS IN HEALTH POLICY (D.M. Cutler & A.M. Garber eds., 2005) (no effect).

64. *E.g.*, John J. Fraser, Jr., *Technical Report: Alternative Dispute Resolution in Medical Malpractice*, 107 PEDIATRICS 602 (2001); Thomas B. Metzloff, Comment, *Alternative Dispute Resolution Strategies in Medical Malpractice*, 9 ALASKA L. REV. 429 (1992).

pecuniary losses,[65] enterprise liability for health outcomes to create better incentives for safety management,[66] "early offer" reform to promote prompt disclosure of bad outcomes and reduced need for lawyers and litigation, in exchange for elimination of the "non-economic" component of tort awards, whose main practical purpose is to fund the high expense of tort process,[67] and fault-based administrative compensation.[68] Of these, only the last sought to build in a quality improvement by having injury compensation and physician discipline administered by the same agency.[69] This proposal from the AMA and medical specialty societies was briefly promoted as an alternative to conventional tort reform, but medical interest groups soon returned to promoting only caps and their ilk. Moreover, of this generation of reforms, only ADR has ever had practical implementation.

The third-generation of reforms consist of longer-term reforms that would make much larger changes, most notably in standards for payment and in incentives for safety. These include what is often called "no-fault"[70] but is more accurately termed administrative compensation for preventable injuries, as Professor Sage has cogently argued. A related but different idea is to replace adjudicatory fault-finding with a system based on expertly pre-determined avoidable classes of events (ACEs), implemented by legislation or by private contract.[71] Administrative compensation has been tried in the form of the Virginia and Florida "bad baby" compensation systems meant to supplant tort for severely neurologically injured newborns—with mixed success.[72]

Where do health courts and Medicare-led reform fit in this typology? Both clearly aim to be third-generation reforms, although many details are under

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65. *E.g.*, Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering,"* 83 NW. U. L. REV. 908 (1989).

66. *E.g.*, William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J. L. & MED. 1 (1994).

67. *E.g.*, Jeffrey O'Connell & Patrick B. Bryan, *More Hippocrates, Less Hypocrisy: "Early Offers" as a Means of Implementing the Institute of Medicine's Recommendations on Malpractice Law*, 15 J. L. & HEALTH 23 (2001).

68. Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365 (1989) (summary of proposal, including changes to medical discipline).

69. *Id.*

70. *E.g.*, David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States*, 27 AM. J.L. & MED. 225 (2001); David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 JAMA 217 (2001).

71. Bovbjerg & Tancredi, *supra* note 16, at 485-94 (building upon work begun by Havighurst & Tancredi, *supra* note 41).

72. Bovbjerg & Sloan, *supra* note 31, note both successes and shortcomings in summarizing their research on the programs; Sage and Kinney, *supra* note 2 at 338, recognize one key shortcoming, underclaiming by families with injured babies.

development or open to negotiation. Their presentations seem in some ways more like proposals for grant funding than like proposals for specific legislation or regulation.

The health courts proposal began as a deceptively simple, second-generation reform to shift the type of court to hear malpractice litigation without changing tort rules.[73] The initial health court proposal from Common Good was simply to replace malpractice juries with expert judges. The traditional medical plaint about juries is their alleged inability to weigh the scientific validity of medical evidence as opposed to the observed demeanor of medical experts.[74] Common Good has added an additional key rationale, that jury-based decision-making is inevitably ad hoc and fails to act as a reliable, predictable source of guidance for health care.[75] Over time, however, the proposal has evolved and added some specificity. Health courts were initially described as traditional courts with expert judges, akin to tax courts, and still sometimes are. However, they are also now described as administrative compensation with administrative law judges, akin to workers' compensation,[76] although not yet the full-fledged health-claims adjudicatory system described for Medicare-led reform. The name health "courts" has been retained despite increasing reference to administrative processes.[77]

Other new elements have also been added, including scheduling of damages, court-appointed neutral experts, and in some presentations, a broader standard of care than avoiding negligence as well as use of ACE lists of avoidable injuries as an adjunct to adjudication.[78] A core principle throughout, however, is that judge-

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73. *E.g.*, Philip K. Howard, *The Best Course of Treatment*, N.Y. TIMES, July 21, 2003, at A15 (op-ed arguing that expert judges should determine whether medical standard of care was met).

74. *E.g.*, Johnson et al., *supra* note 68, at 1379.

75. *E.g.*, *Common Good petition*, *supra* note 19.

76. *E.g.*, Troyen A. Brennan & Philip K. Howard, *Heal the Law, Then Health Care*, WASH. POST, Jan. 25, 2004, at B7 ("special health court or administrative compensation scheme"). Common Good is currently collaborating with analysts at the Harvard School of Public Health (Dr. Brennan's former institution) on a foundation-funded project to develop the administrative compensation model. 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, http://www.hsph.harvard.edu/press/releases/press001102005A.html.html.

77. For example, Udell and Kendall say that claims should no longer be in "civil courts," but instead in "administrative processes overseen by the states . . . similar to . . . workers' compensation." Udell & Kendall, *supra* note 19, at 3. They also argue that judges should be similar not to state administrative law judges but rather to judges in federal tax or patent courts. *Id.* at 9.

78. Udell and Kendall is the most detailed presentation. *Id.* The Barringer 2005 presentation also mixes judicial and administrative models, describing "adjudication" as "[e]xpert panel or judge" (slide 3), and later argues "Special courts exist in other areas of the law - Examples: tax, workers' compensation, vaccine liability" (slide 27). The finished article evidently shows similar ambiguity. Tax is handled in specialized federal courts, while workers' compensation disputes are resolved through state administrative adjudication—two rather different processes. The childhood vaccine compensation structure is different still. *See New Prescription*, *supra* note 19, at 236; HEALTH RES. & SERVS. ADMIN., *infra* note 110.

made determinations on the applicable standard of care should create binding precedent, with the force of law, to guide medical practice.[79] The proposal's main tie to patient safety is that it will be more expert, drawing on available national standards and national neutral experts rather than experts on local customary care.[80] Some imprecision on provisions is understandable in light of Common Good's posture that it remains flexible and open to suggestions for improvement of health courts.

Medicare-led reform is harder to summarize briefly because it already is much more detailed, even though in practice it might take fewer steps to implement. The proposal's central insight is that the country's largest health care payer—Medicare—naturally has leverage with medical providers as well as analytical capabilities unavailable to any stand-alone compensation system, whether the latter is judicial or administrative. Equally important, Medicare has two dispute resolution mechanisms that already deal with issues needing medical expertise to resolve. First, it has a history of using administrative adjudication to resolve payment disputes, which often turn on medical evidence about whether a service was medically necessary.[81] Second, it has a new ombudsman program meant to find potential injuries and safety issues that can accompany patient complaints.[82]

Thus, argue the authors, Medicare could adapt its adjudicative capacities to resolve claims of injury from substandard care. It could simultaneously use its

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79. *See* Howard, *supra* note 73; *New Prescription*, *supra* note 19, at 245.

80. Udell & Kendall, *supra* note 19, at 12-14.

81. This function is traditional, but actual operations of adjudication are being conducted in a brand new bureaucratic framework after a move from SSA to HHS. The new legal provisions are part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 and are described in Sage and Kinney, *supra* note 2, at 329. However, the story appears to be much richer than indicated. The transfer evidently began when the Medicare Regulatory, Appeals, Contracting, and Education Reform Act of 2001 directed SSA and HHS to come up with a plan for transfer. H.R. 3046, 107th Cong. (2001). It would have been helpful for Sage and Kinney to have reviewed the policy literature and legislative history of this move; there must have been considerable dissatisfaction with traditional performance to occasion such a major change. Casual contemporaneous reading of the health policy trade press suggested that the general reputation of SSA's administrative adjudication was not strong. *See, e.g.*, U.S. GEN. ACCOUNTING OFFICE [now GOV'T ACCOUNTABILITY OFFICE], MEDICARE APPEALS: DISPARITY BETWEEN REQUIREMENTS AND RESPONSIBLE AGENCIES' CAPABILITIES, REPORT TO THE COMMITTEE ON ENERGY AND COMMERCE, HOUSE OF REPRESENTATIVES no. GAO-03-841, 20-22 (2003). Moreover, the plan for bureaucratic transfer came in for some withering criticism. *E.g.*, U.S. GOV'T ACCOUNTABILITY OFFICE, MEDICARE: INCOMPLETE PLAN TO TRANSFER APPEALS WORKLOAD FROM SSA TO HHS THREATENS SERVICE TO APPELLANTS, REPORT TO CONGRESSIONAL COMMITTEES no. GAO-05-45, 2-7 (2004). Viewed most favorably to Medicare-led reform, as Sage and Kinney present it, the transfer can be seen as shifting from an income-transfer locale to one focused on medical care and quality. One hopes that further development of the authors' ideas about Medicare adjudicatory processes will, like Kinney's typical scholarship, go beyond describing the statutory intent and regulatory framework.

82. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003) (codified at 42 U.S.C.A. § 1395-9 (West. Supp. 2005)).

leverage to get hospitals and large physician groups to change how they address medical mishaps in numerous ways consistent with patient safety orthodoxy. This includes creating effective internal reporting systems, relating more responsibly with injured patients, offering reasonable compensation—all before any claim is made—as well as learning more about how to prevent similar problems in the future and following national recommendations on best safety practices. Separately, Medicare could create new injury-safety tools from existing quality mechanisms like the Quality Improvement Organizations that already review services and from "data mining" within its voluminous flow of health claims, utilization, and other information. The authors discuss use of ACEs to simplify determinations, and different rules of responsibility and damages also get brief mention. At the current stage of development, Medicare-led reform also leaves some loose ends.

Both proposals envisage eventual national implementation, but propose to start with time-limited state or regional demonstrations. Medicare-led demonstrations might also be limited to hospitals and large medical groups that volunteer to implement change and possibly also to patients who freely agree to patronize them. As the old joke goes, it only takes one psychotherapist to change a light bulb . . . but the light bulb really has to want to change. Given the extensive changes that the reform expects of participating institutions, starting with volunteers is quite sensible. Doing demonstrations prior to implementation is also quite sensible, as wider acceptance calls for clear documentation of improvements over tort.

## V. SOME STRENGTHS AND WEAKNESSES OF THE TWO PROPOSALS

Most of the strengths and weaknesses of both proposals relate to implementation. Some other concerns also merit attention.

### *A . Implementation*

Implementation has been the Achilles' heel of many a promising policy idea. An entire literature of public policy explicates the difficulties of successful implementation, including a subgenre of caveats on unexpected consequences.[83] The proponents of health courts and Medicare-led reform have had implementation clearly in mind. They both seek to re-tailor the existing policy wardrobe rather than fashion anew from whole cloth. Calling for better courts seems tailored to assuage future jurists considering their operations and validity on judicial review. Piggybacking liability reform on Medicare's existing adjudicatory capabilities

83. The seminal thinking on the topic was published thirty-three years ago. *See generally* JEFFREY L. PRESSMAN & AARON WILDAVSKY, IMPLEMENTATION: HOW GREAT EXPECTATIONS IN WASHINGTON ARE DASHED IN OAKLAND; OR, WHY IT'S AMAZING THAT FEDERAL PROGRAMS WORK AT ALL (1973).

should facilitate implementation. Tying reform to medical quality and entrusting operations to an agency at least indirectly answerable to beneficiaries provides some assurance that this is not the earlier generation's takeaway tort reform, which is politically astute. Overall, the proposals' one-page-memo story is relatively easy to present and justify, and this simplicity could ease implementation and provide some preemptive defense against inevitable political attacks.

In building momentum for reform, the health courts proposal to date shows greater progress in wooing public and political support for change. Medicare-led reform shows more progress in legal and administrative planning and justification. For the future, each proposal will need to take some plays from the other's playbook.

Two other very insightful points made for Medicare-led reform deserve mention. One is that Medicare is overseen by different congressional committees than would consider liability-reform legislation.[84] The other is repetition of an earlier suggestion that federal reinsurance for very high payouts could serve as a funding/risk-reducing mechanism that would increase the attractiveness of reform—and thus ease implementation. Reinsurance can provide value to institutions that well exceeds its cost to government. Moreover, a promise to reinsure future losses does not require a current cash outlay, which should be helpful in today's budgetary climate in Washington, D.C.[85]

A closer look suggests more complexities in implementation than at first appear. For example, health courts when described more fully turn out to anticipate state reform under a federal aegis as well as national standards.[86] They thus seem to require both federal and state legislation. Reforms of any complexity, as health courts have now become, are very hard to get legislated as designed. This is one reason for the persistence of the century-old analogy that legislation is like sausage-making—reformers can propose salami and end with bologna.[87]

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84. Such seeming minutiae can be very influential in an initial enactment and in subsequent operations. *See generally* ERIC REDMAN, THE DANCE OF LEGISLATION (1973); T.R. REID, CONGRESSIONAL ODYSSEY: THE SAGA OF A SENATE BILL (1980); RICHARD F. FENNO, JR., THE MAKING OF A SENATOR: DAN QUAYLE (1989).

85. Reinsurance was first described in an IOM chapter whose lead drafters were Sage and Robert A. Berenson. COMM. ON RAPID ADVANCE DEMONSTRATION PROJECTS: HEALTH CARE FIN. AND DELIVERY SYS., INST. OF MED., FOSTERING RAPID ADVANCES IN HEALTH CARE: LEARNING FROM SYSTEMS DEMONSTRATIONS 81-90 (Janet M. Corrigan et al. eds., 2003), *Openbook-viewable from* http://www.nap.edu/books/0309087074/html.

86. Udell & Kendall, *supra* note 19, at 4.

87. The sausage analogy is generally attributed to 19th century Chancellor Otto von Bismark of Germany, interestingly also a father of social insurance and workers' compensation. For a less colorful and more scholarly examination of the problems of implementing auto insurance reform to follow in the path of no-fault for workers compensation, see Bovbjerg & Sloan, *supra* note 31, at 79-81. For a somewhat defensive attack on the sausage-making analogy, see Alan Rosenthal, *The Legislature as Sausage Factory: It's About Time We Examine This Metaphor*, STATE LEGISLATURES, Sept. 2001, *available at* http://www.ncsl.org/programs/pubs/901sausge.htm.

Professors Sage and Kinney's scholarship for Medicare-led reform is strong on the legal and regulatory authority underpinning the proposal.[88] Much less is presented about the practicalities of implementation. The Secretary of the Department of Health and Human Services (DHHS) has considerable legal authority to run demonstrations, as they suggest. But the Secretary has much less practical ability to make any particular demonstration happen, and very little chance of enforcing a change that is resisted by powerful medical or political actors.

Two key issues should be addressed in future work. First, demonstrations require funding even if not new substantive authority, which makes Congressional relations important.[89] Moreover, for the most part demonstrations also require on-the-ground participation with some degree of enthusiasm to succeed in nurturing the implementation needed to test a new idea. Many Medicare demonstrations have failed for want of one or the other.[90] Another cautionary tale for federal civil servants is the near-death experience of the former Agency for Health Care Policy and Research, which was vigorously attacked by medical groups opposed to one medical practice guideline developed by a grantee, and which had to be reborn with an altered focus as the Agency for Healthcare Research and Quality.[91]

It is therefore good that the proposal also devotes attention to how to make many of its aspects attractive to medical institutions, especially volunteer implementers. Going forward, a great deal of attention needs to be paid to making reform attractive to potential reform-implementers as well as to us policy wonks.

A final concern to note about implementation is whether the proposed changes provide enough leverage to change provider behavior in all the ways contemplated by Barringer and Common Good and by Professors Sage and Kinney. Health courts have the advantage that they propose to affect all of medical liability, hypothesized to be a big change in incentives for providers. This big

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88. The most detailed presentation appears to be Kinney and Sage, CONN. INSUR. LAW J., *supra* note 19.

89. Moreover, the big push for Medicare analysis of safety and for data-driven management envisaged by Sage and Kinney seems to be an uphill struggle to implement in light of the very small share of program spending that Medicare and Medicaid now devote to analysis of program data.

90. Your commentator had personal experience with a meticulously planned demonstration of a form of competitive bidding for Medicare dialysis services in two geographic locations. They failed in the face of provider resistance, Randall R. Bovbjerg et al., *Provider-Patient Relations and Treatment Choice in the Era of Fiscal Incentives: The Case of the End-stage Renal Disease Program*, 65 MILBANK Q. 177, 182 (1987). Colleagues at The Urban Institute had similar experience with more recent failed bidding demonstrations. Len M. Nichols & Robert D. Reischauer, *Who Really Wants Price Competition in Medicare Managed Care? Why Medicare's Latest Competitive-Bidding Demonstration Bit the Dust*, 19 HEALTH AFF. 30, 37-41 (2000); Nancy-Ann Min DeParle & Robert A. Berenson, *The Need for Demonstrations to Test New Ideas*, 19 HEALTH AFF. 57, 58 (2000).

91. *See* Bradford H. Gray et al., *AHCPR and the Changing Politics of Health Services Research*, HEALTH AFF. W3-283 (Web exclusive, 2003), http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.283v1.

legal change is, however, disconnected from all the practical operations of medical institutions that influence the quality and safety of care. Medicare-led reform, in contrast, has the advantages its advocates highlight of being able to use other levers in addition to liability change to alter behavior. Relying on volunteers for early adoption also makes change more readily implemented. These are big pluses.

A substantial minus is that reform for Medicare alone will leave at least two-thirds of the traditional liability system in place, potentially undercutting the incentives sought to be created by the new approach to Medicare injuries.[92] It will be very important for Medicare to use its other tools in service of changes in quality and safety; marginal liability change seems unlikely to do the job by itself.

### *B. Evidence-Based Medicine and Injury Resolution*

It is quite appealing to urge that medical injury resolution make more use of quality standards from evidence-based medicine, as these papers sometimes do. A good deal more high-level thinking is needed, however, about the similarities and differences among multiple types of standards. One standard concerns what care is socially *appropriate* as an attempt to reduce risk to patients' life and health from illness or injury. Such standards have traditionally been implicit rather than explicit, based on conventional practice and "medical necessity" as practicing physicians perceive it. This type of standard underlies everyday Medicare reimbursement policy—and is implicated in the current adjudications of "beneficiary appeals" of health claims disputes, Medicare's experience, described as analogous to expert injury resolution. [93]

Another type of standard embodies aspirational goals or new requirements determined to be socially *desirable* for improving the quality of services beyond what is now delivered and paid for. This typically means that some identified intervention has been observed to reduce the level of risk of bad outcome by a statistically significant and not insubstantial percentage. Here is where "evidence based" medicine comes in, along with ways to get its lessons to practitioners so as to have practical impact on front-line decision-making about the diagnosis and treatment of each patient.[94]

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92. A big traditional concern for hospitals has been keeping safety and peer review information confidential lest attorneys troll for clients, legal theories, and evidence in those records. *See* TO ERR IS HUMAN, *supra* note 11, at 93-117. One expects that further development of Medicare-led reform will give this concern considerably more attention.

93. Sage and Kinney, *supra* note 2, at 327-29.

94. The literature is voluminous. Two seminal articles on evidence-based quality improvement are Glenn Laffel & David Blumenthal, *The Case for Using Industrial Quality Management Science in Health Care Organizations*, 262 JAMA 2869 (1989) and Donald M. Berwick, *Continuous Improvement as an Ideal in Health Care*, 320 NEW ENG. J. MED. 53-56 (1989); *see also* Bibliography, *Articles containing "evidence based Medicine" in Title, 1992-present*, http://www.garfield.library.upenn.edu/

A final type of standard is how to judge whether the actual clinical care given to a particular patient was in a legally definitive way responsible for a particular bad outcome. For tort the standard is negligence plus causation plus injury with cognizable damages, as established by expert testimony, again mainly based on implicit standards. For third-generation reformers, the standard of responsibility is usually broader, often "preventability" or "avoidability" of injury; various versions of these proposals seem to use different formulations at different times. Typically, negligent or preventable harm has to do with the *carefulness* with which the *care* was given, even though in tort the same term, "standard of care," is used for both types of determination. Where a claimant asserts that failure to use some intervention was the cause of harm, the underlying choice of what care to give is implicated, however. More clarity is needed in future discussions of just what new standards are to serve what purpose.

In the meantime, a key point is that a determination that particular interventions help reduce health risks somewhat as a *general* matter—and should therefore generally be provided—is not the same thing as a determination that a *particular* failure to give it caused an injury (or, under reform, that any ensuing injury of particular types was preventable). Therefore, it seems unwise to rely overmuch on the idea that quality-oriented evidence and standards will readily be adapted as standards for injury resolution. Likewise, the experience of Medicare administrative law judges in applying standards of medical necessity seem quite different from determining negligence, causation, or preventability of injury.

Contrary to what Barringer and other Common Good authors seem to suggest, it also seems quite unwise to urge that injury resolution decisions should definitively set *the* "standard of care" for all medical care—if what they mean is that judges resolving individualized disputes will decide what care should routinely be delivered and paid for. The issues of carefulness of particular behavior or preventability of particular injuries are different from what care should be given as a general matter. Legal forums are also not good for setting payment policy because they can never consider the full range of evidence needed and because they have no obligation—indeed, no mechanism—for factoring in the cost-effectiveness of services. Standards of medical appropriateness and quality deserve meta-reviews of literature and the style of expert decision-making that the National Institutes of Health or Institute of Medicine consensus panels can contribute.[95]

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histcomp/evidence-b-med_92-04/index.html (last visited Sept. 21, 2006); Oxford University, Centre for Evidence-Based Medicine, Institute of Health Sciences, Home Page, http://www.cebm.net/ (listing similar institutions around the world at http://www.cebm.net/ebm_links.asp) (last visited Sept. 21, 2006).

95. Another option could be a "Health Care Fed," akin to the British NICE (National Institute for Clinical Excellence), to disseminate authoritative information on best clinical practices. *E.g.*, Frank Diamond, *Making the Case for a 'Health Care Fed': Should Uncle Sam Decide What Works?*,

Judges, who have to resolve every case brought before them, should use whatever authoritative quality standards are available for their limited relevance regarding individual injury. Judges should not, however, fill in the gaps by creating new standards for all of health care when such consensus does not previously exist; they should just decide the case before them. Law needs to have more modesty about its own scope. It seems very undesirable for any single judge, regardless of how expert, to promulgate a binding national medical standard, certainly not for payment policy or what quality enhancements should have top priority for implementation. And no single injury dispute can illustrate all the important factors relevant to general policy; the emotional context of the severe medical injury cases most likely to be disputed are an especially poor context within which to set standards for general application.

### *C. Scheduling Damages*

Making payouts for injury resolution more predictable and more consistent across cases is an important goal for reform. "Scheduling" of damages is a shorthand way to cover various approaches toward this goal, and both reforms under discussion call for scheduling. The author has long argued for a more structured approach to damages on grounds of both efficiency and equity.[96] Readers should appreciate, however, that scheduling does not usually mean a simple listing of injuries with corresponding numerical values akin to a train schedule or the old workers' compensation values for traumatic injury like loss of a hand. Reform could come close to a simple list only for non-monetary damages like "loss of enjoyment of life," which are routinely mislabeled as "non-economic," although they have a very real economic value.

The two proposals sometimes fail to keep the limited nature of scheduling clear, and it is not desirable to imply that routinizing any element of damages is extremely straightforward. It is not. Even for non-monetary losses, the most feasible approach to implement would create ranges of values as guidance for decision-makers. How much allowance any reform should make for non-pecuniary loss, given various possible expansions of entitlement to monetary damages beyond tort restrictions to negligent injuries, is another issue to be determined—and not emphasized in either paper.

The other main elements of damages are monetary, wage losses and medical expenses. Future wage losses can in theory be quasi-scheduled as under workers compensation or disability insurance policies that pay a percentage of last wage level or a percentile of some identified category of wages, normally for a limited

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MANAGED CARE MAG., Jan. 2002, *available at* http://www.managedcaremage.com/archives/0201/0201.hcfed.html.

96. *See, e.g.*, Bovbjerg et al., *supra* note 65; Bovbjerg & Raymond, *supra* note 35, at 13-17.

term of years. Discussing the merits of such limits is going to need to be part of further development of reforms; it is not really in these papers or this commentary.

Future medical bills appear to be a major and growing component of very large malpractice awards and are a big challenge to "schedule." Standardized rates for expected inflation or appropriate discount factors could readily be made consistent across cases, however, and health courts or Medicare administrative adjudication lend themselves to implementing such general rules, quite unlike state tort law and juries. Insurance-like schemes to care for injured people going forward could also replace jury "guesstimates" about future medical needs and costs.[97]

A very misleading impression may be created by citing European or antipodean experience with damage schedules without explaining that countries use them mainly for non-monetary damages. Other countries "schedule" wage losses and medical bills in a very different way, because they have extensive social insurance for disability, job loss, and medical costs that is applicable for all injury or illness. Those benefit programs standardize benefits, much as Social Security and Medicare do here, by applying benefits and payment rules consistently for all beneficiaries, in an ongoing fashion and subject to changes in light of altered circumstances. Scheduling damages is entirely another matter. The Medicare presentation provides much more sophistication by mentioning that Medicare has become more attuned to catastrophic needs of those with permanent injuries, who are very badly served by current benefit design, and to the desirability of changing benefit structure to provide more assistance through ordinary program operations, not through injury adjudication.[98]

## VI. THE CENTRAL IMPORTANCE OF ACES

Both proposals emphasize adjudicative processes as the key to malpractice reform, whether in specialized courts or by specialized administrative law judges. They mention "avoidable classes of events" (ACEs) only in passing, as a way to make adjudication run more smoothly.[99] As expert listings of automatically compensable events, ACEs are arguably much more than that, not a mere adjunct but a central element that will dominate the practical effect of either system.[100]

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97. James F. Blumstein et al., *Beyond Tort Reform: Developing Better Tools for Assessing Damages for Personal Injury*, 8 YALE J. ON REG. 171, 190 (1991).

98. Sage and Kinney, *supra* note 2, at 322, 342, and *passim*.

99. *New Prescription*, *supra* note 19, at 247; *Medicare Malpractice Reform*, *supra* note 19, at 226.

100. To avoid a misimpression that these papers may create, readers should note that the ACE idea has evolved through three generations itself. The initial publication was Havighurst & Tancredi, *supra* note 41, at 125, which drew upon deliberations of Havighurst's Committee on Legal Issues in Health Care and Tancredi's honors thesis at Yale. The second generation created an acronym and generated listings from summary NAIC malpractice data, J.R. Boyden and L.R. Tancredi, *Identification of Designated Compensable Events (DCEs)*, *in* AM. BAR ASS'N COMM'N ON MED. PROF. LIABILITY.

This subsection argues that getting the ACEs right is at least as important as who decides cases not covered by ACEs. ACEs should resolve most injuries without dispute. From this perspective, the dispute resolution system is ancillary and need not be used to drive injury policy the way that tort liability does. Residual dispute resolution could be public or private, judicial or administrative, and still have much the same overall impact if the ACEs are the same.

Indeed, without ACEs, neither system is likely to achieve the stated goals of increasing the number of avoidable injuries compensated and achieving large efficiencies in the speed and cost of claims processing. Both adjudicatory systems described are *claims-based* systems. Claims-based administrative adjudication is faster and cheaper than courtroom adjudication, but it is still case by case adjudication requiring many talented (and pricey) people and many delays. The process goal of ACEs is to make injury resolution operate more disability or health insurance and less like liability insurance.

Simply as adjudicative reforms, moreover, both health courts and Medicare-led reform are likely to face very similar patterns of under-claiming and misguided claiming that plague the traditional tort adjudicatory system. To its credit, the Medicare-led reform proposal suggests that the new approach will promote early disclosure of problems.[101] That is highly desirable. What also needs to be disclosed is that the medical culture of silence about mistakes and injuries runs deep, as Rosemary Gibson has persuasively described.[102] Reluctance to disclose or discuss error is not limited to medicine and is not limited to physicians fearful of the American liability system, although the latter certainly further discourages disclosure. The medical tradition of silence goes back to antiquity, and it exists around the world, in countries with dispute resolution much more like the reforms proposed in these papers.

Medicare has regulatory and payment levers to promote changes in behavior, but even legal mandates do not automatically achieve compliance. Many forms of mandatory reporting still have under-reporting, including malpractice claims to the National Practitioner Data Bank and adverse drug event reporting to the FDA.[103] Safety managers within hospitals have a hard time getting full reporting about

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DESIGNATED COMPENSABLE EVENT SYSTEM: A FEASIBILITY STUDY 11-51 (Chicago, IL: ABA, 1979). The third generation created a more pronounceable and descriptive acronym, used more data to create more ACEs, applied ACEs to obstetric closed claims files, and developed a proposal for demonstration testing, *e.g.*, 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 (1991).

101. Sage & Kinney, *supra* note 2, at 344-45; *Medicare Malpractice Reform*, *supra* note 19, at 228.

102. GIBSON & SINGH, *supra* note 37.

103. *See* Randall R. Bovbjerg, *Patient Safety and Physician Silence*, 25 J. LEGAL MED. 505, 510-13 (2004) (discussing under-reporting of physician error); Bovbjerg & Tancredi, *supra* note 16, at 482 (noting that despite ethical and regulatory strictures favoring honest disclosure to patients, disclosure is still lacking).

incidents within an entirely internal and confidential basis. Good reporting comes when it is in reporters' self-interest to report—and when there's an objective way to spot non-reporting. Both of these can be observed in the safety systems used for aviation.[104] Crashes are obvious and investigators are immediately notified. "Close calls" are not obvious, and they are reported because pilots and crew benefit personally from safety analysis and because their reports are fully confidential, indeed de-identified, once content is verified.

ACEs make preventable injuries almost as visible as airline crashes. This is a much more reliable system for disclosure than Medicare can create. Non-ACEs must still be dealt with, and for finding and resolving them, Medicare-led reform is much superior to health courts.

ACEs also promise a more reliable and predictable basis of injury resolution than does the prospect of slow accumulation of precedent from health courts or administrative law judges. Of course, like any reform, ACEs require substantial upfront effort. They also need to be implemented properly, which is a challenge for them, too. Fully discussing these issues calls for a different symposium, but these points deserve more than the passing mention given in these proposals to date.

Pace these professors, a quite detailed ACE proposal was developed and circulated in search of volunteer implementers during the early to mid-1990s.[105] The proposal joined the ACE idea with Professor Jeffrey O'Connell's "early offer" tort reform;[106] O'Connell was a member of the project team. The essential idea was to create an alternative injury resolution system using private contracts under ERISA's preemption of tort liability for employee benefits plans, just as Medicare-led reform would preempt tort. The contracts would promise a better alternative than the liability system to beneficiaries, along with good health care, of course—akin to the "earn in" idea of Medicare-led reform. The proposal was to begin with obstetrics because of its clear appeal as a "motherhood issue" and because obstetrics faced severe problems under tort, then as now.

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104. *Paths to Reducing Medical Injury*, *supra* note 14, at 373 (explicating a favorite analogy of patient safety between airline and medical safety systems).

105. Sage & Kinney, *supra* note 2, say of workplace-based private reform of malpractice: "No formal proposals taking this approach have been circulated." To the contrary, the third generation of ACE research developed but was unable to implement such an approach. *See* Randall R. Bovbjerg et al., *Injury Monitoring, Avoidance, and Resolution: "ACEs" for Quality and Malpractice Reform* (Aug. 30, 1993, proposal to the Robert Wood Johnson Foundation); Randall R. Bovbjerg et al., *A Demonstration Project for Reforming Ob/Gyn Liability: Early Offers of Settlement Based on Avoidability of Adverse Outcomes, Frequently Asked Questions*, May 5, 1995 (set of questions and answers provided to potential implementers).

106. *Offers that Can't be Refused: Foreclosure of Personnel Injury Claims by Prompt Tender of Claimant's Net Economic Loss*, 77 NW. U.L. REV. 589 (1982); Sage and Kinney propose consideration of early-offer provisions in their section on "compensable events," *supra* note 2, at 342.

To offer further assurance that the system would serve patient interests, the health plan and its providers were to bind themselves contractually to make early offers of reasonable compensation for all ACEs—a somewhat stronger vow than Medicare conditions of participation—and, unlike most Medicare rules, a promise enforceable by beneficiaries. The advance listing of ACEs would prevent strategic, selective offers by the plan. Residual claims and all disputes were to be resolved by private arbitration using tort rules.

One health plan, an HMO, signed on as an implementer, but foundation funding was rejected on the ground that the proposal could not promise in advance to fully implement a new form of compensation, given all its financial and reputational risks. The proposal envisioned instead a period of implementation planning, with creation of the ACE list for obstetrics by the American College of Obstetricians & Gynecologists (ACOG), simulation of likely costs from incident reports, utilization data, and liability claims histories, and legal analysis of the robustness of the proposed ERISA contract to shelter the arrangement for legal attack—all of which were elements of implementation planning.

One lesson of this history for current reformers is that is important not to try to cater to demands for quick achievement of all long-term goals. The negligence system has taken 150 years to evolve, and "modern" medical liability dates from the 1950s and 1960s. One must crawl before one can walk, and walk before run. The encouragement from this corner is for these reformers to consider phased implementation (which is in part what demonstrations facilitate) and achievement of goals in priority order. For its part, demonstration of an ACE-based reform outside of Medicare remains desirable today.[107]

## VII. TWO EVEN MORE READILY IMPLEMENTED REFORMS

### *A. The vaccine compensation model*

Federal vaccine compensation features many of the advantages claimed for health courts without the need to reinvent the wheel.[108] This injury compensation

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107. *See Paths to Reducing Medical Injury, supra* note 14.

108. The Vaccine Injury Compensation Program combines administrative and judicial elements and hence may be an excellent model for health courts. Claims, or petitions, are submitted to the Division of Vaccine Injury Compensation within the Health Resources and Services Administration of the U.S. Department of Health and Human Services. Medical reviewers review petitions for compensability, and U.S. Department of Justice attorneys representing DHHS provide the recommendations to special masters working with the U.S. Court of Federal Claims. The special masters make initial decisions on compensation, which may be appealed to a judge of the Court, then to the Federal Circuit Court of Appeals, and then to the Supreme Court. Health Res. & Services Admin., DHHS, National Vaccine Injury Compensation Program, Filing a Claim with the VICP, http://www.hrsa.gov/vaccine compensation/filing_claim.htm (last visited Sept. 21, 2006); *see Paths to Reducing Medical Injury, supra* note 14.

program provides an already operational system on which to graft resolution of more general medical injuries. There are no juries, and judges are unelected. Necessary expertise is supplied by special masters rather than special, new medical judges.[109] Vaccine injury disputes are simplified by a list of automatically compensable adverse vaccine reactions, akin to ACEs. This model deserves much more attention than it has received among analysts generally and from either of the two instant proposals.

### *B. The Federal Tort Claims Act*

Finally, perhaps the conceptually simplest implementation of all would be to put all Medicare providers under the Federal Tort Claims Act (FTCA). The FTCA already resolves many medical injury cases involving federal medical providers, including the Veterans Agency (which features very advanced patient safety and quality, partly facilitated by the FTCA), the Public Health Service, and the Indian Health Service. Administration occurs through tort processes, and disputes are resolved by federal courts' following state substantive tort law. Federal courts have arguably more expert and dispassionate, unelected judges, no jury trials, and no punitive awards. Funding could come from the providers themselves, as it does now. A side benefit could be making Medicare participation even more attractive to providers.

An intriguing variant would be to have the federal government also assume the risk of claims payouts and possibly also provide defense counsel, as it does today for federal organizations. This approach would give providers major benefits in terms of liability premiums avoided and reduced fear of litigation and its attendant "hassle," although basic costs of time lost from practice to prepare and testify—and perhaps some social stigma—would remain. These new federal costs could be recouped at least in major part by eliminating malpractice premiums as an element in provider payment. Medicare does a weak job of recognizing those costs, by slow-moving survey of insurers and a three-year update cycle.

There is precedent for going beyond federal employees to independent recipients of federal funding. The FTCA has already been extended to federal program beneficiaries in the form of HRSA section 330 health centers.[110] This

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109. As a general matter, masters are like most judges in being able to work on different types of cases, although they may specialize. The adaptability of the special master model is shown by its use to resolve claims arising from the 9-11 atrocities. That experience also provided an object lesson in the difficulty of scheduling damages. *See 9/11 Fund's Special Master Recounts Experiences*, University of Virginia School of Law, Sept. 22, 2004 (interview with Kenneth Feinberg, with audio recording of his speech at the Student Legal Forum on Sept. 21st), *available at* http://www.law.virginia.edu/home2002/html/news/2004_fall/feinberg.htm.

110. Health Res. & Servs. Admin., U.S. Dep't of Health & Human Servs., Federal Tort Claims Act and Health Centers: Medical Malpractice Liability Protection, http://bphc.hrsa.gov/risk/default.htm (last visited June 18, 2006); *see* HEALTH RES. & SERVS. ADMIN., DEP'T OF HEALTH & HUMAN SERVS.,

assumption of liability has been followed by a singular lack of public complaint or media attention to problems from either the perspective of the health centers or of the federal government. What is proposed here would be considerably more costly and more distressing to those whose livelihood derives from state tort litigation, however, and would provoke much more resistance. States' rights conservatives, often Republicans, would also object, but some defense-oriented constituencies, also often Republican, might be pleased. Enhanced scope for more consistent national rights has often been a Democratic issue. Perhaps such a proposal could redraw some of the political battle lines over tort reform.

Finally, consider other side benefits of federal responsibility. For the first time, the costs of the liability system (and of liability insurance, if used) could be known with some precision, and in real time, not from special studies after the fact. Through Medicare morbidity and mortality research, furthermore, relationships of liability experience and health outcomes might be studied. Claims rates and their relationship to population data could be assessed—all the benefits suggested for Medicare-led reform and possibly more.

Consider the implications. A major social system could thus actually be judged by many of its observed costs and benefits. What a pleasant change from traditional battles about tort reform and medical, legal, and insurance performance. This picture may be unduly simplified, as for any reform proposal in its initial stages. The approach nonetheless merits much more serious consideration.

## VIII. SUMMING UP

Many goals of conventional tort reform are quite legitimate—to calm skittish insurance markets, to reduce the volatility of claims payout trends, to make legal processes faster and cheaper, to avoid the excesses of some verdicts (though not the shortfalls of many). A public-interest perspective suggests that these efforts should more often take the form of even-handed tort reforms that improve the process rather than help one side against the other. A longer-term, even more productive goal for reform is to make it easier for patients to recognize injuries and quickly receive reasonable compensation, for achieving results that are more consistent across cases, and for making the entire process less threatening to caregivers and more congruent with patient safety efforts. The two reforms of health courts and Medicare-led reform seek many of these same goals.

It is increasingly recognized that successful legislation for and successful implementation of social reforms calls not only for a good design, but also for

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FINAL FY 2005 GPRA ANNUAL PERFORMANCE PLAN (2004), *available at* ftp://ftp.hrsa.gov/hrsa/05perplan.pdf.

talented and dedicated "policy entrepreneurs" with the practical savvy and inspirational charisma to see things through.[111]

In Mr. Howard, Professor Sage, and their colleagues, third-generation reforms of medial liability have found excellent salesmen. Let us hope that they are successful policy entrepreneurs as well. It is past time to undertake such demonstrations of alternatives to our under-performing liability system.

111. *See, e.g.*, Nancy C. Roberts & Paula J. King, *Policy Entrepreneurs: Their Activity Structure and Function in the Policy Process*, 1 J. PUB. ADMIN. RES. & THEORY: J-PART 147 (1991); Thomas R. Oliver and Pamela Paul-Shaheen, *Translating Ideas Into Action: Entrepreneurial Leadership in State Health Care Reforms*, 22 J. HEALTH POL. POL'Y & L. 721, 743-73 (1997).